H.R. 1443 AND OVERSIGHT OF THE VA'S READJUSTMENT COUNSELING PROGRAM FOR VIETNAM-ERA VETERANS

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BEFORE THE
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H.R. 1443 AND OVERSIGHT OF THE VA'S READJUSTMENT COUNSELING PROGRAM FOR VIETNAM-ERA VETERANS

THURSDAY, MARCH 24, 1983

U.S. House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to notice at 9 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Mica, Evans, Kaptur, Mollohan, Penny, Staggers, Rowland, Richardson, Daschle, Hammerschmidt, Smith of New Jersey, Bilirakis, and Johnson.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. Edgar. The Subcommittee on Hospitals and Health Care will come to order.

I would like to welcome everyone here this morning. The purpose of this morning's hearing will be to review the VA's readjustment counseling program for Vietnam-era veterans. The subcommittee will also receive testimony on H.R. 1443,[1] legislation I have introduced to amend title 38, United States Code, to extend eligibility for readjustment counseling and related mental health services for Vietnam-era veterans through September 30, 1985.

The same legislation would also authorize the Veterans' Administration to conduct a major study of the Vietnam-era veteran population. The study would determine the agency's ability, now and in the future, to provide for the continuing readjustment and health needs of these veterans and to provide an assessment of the readjustment, economic, social, and health status of the population. The study would be designed to isolate distinct characteristics and trends among service-connected disabled veterans, veterans who served in the Vietnam theater of operations, and women veterans.

The readjustment counseling program, almost 10 years in development, was finally authorized by the Congress in 1979. The program was founded on two major premises. First, the Congress acknowledged that a significant portion of the Vietnam-era veteran population was continuing to experience readjustment difficulties in adapting to civilian life. Second, this targeted population could not, or would not, avail themselves of traditional VA mental health services.

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[1] See p. 81.

During the hearings leading to this legislation it was made clear that existing VA services were not receptive to the unique nature of the disorders currently being experienced by the Vietnam-era veteran population. As a result, the vet center concept was established by law and apart from traditional VA facilities, in storefront locations to provide outreach, peer group counseling, and mental health assessment for these veterans.

The purpose of this program has been dramatic and the response has been very good. During this fiscal year alone, vet centers will provide counseling for an estimated 80,000 Vietnam-era veterans. The program has enhanced the VA's international reputation as a recognized leader in the study and treatment of combat and stress disorders.

In 1981 the Congress reauthorized eligibility for these services. Under current law, eligibility will again terminate for new clients as of September 30, 1984. Six months prior to that date the VA is required to submit to the Congress a report on how readjustment counseling services will be phrased into VA health care facilities.

This committee is concerned that the demand for readjustment counseling services provided by the vet centers could very well continue far beyond the planned termination date of the program. Further, I believe there is concern as to the ability of the VA mental health services to absorb this function within the timeframe called for under existing law. At this point in time, the program has not reached its maximum potential.

Nearly one-third of the existing 136 centers have been operating for 1 year or less. Under the Budget Reform Act of 1974, the Committee on Veterans' Affairs must report any action in this regard to the full House not later than May 15, 1983, if the program is to be extended and funded beyond September 30, 1984. In other words, we would lose an entire fiscal year, and these counseling services would be seriously disrupted. Judging from past history, perhaps this program has been disrupted enough.

The legislation I have introduced, H.R. 1443, would extend the existing authorization for readjustment counseling services for Vietnam-era veterans through September 30, 1985. This extension would insure additional continuity of services within the program for 1 additional year. My colleague, Dan Mica of Florida, has introduced H.R. 2213,[2] which is similar to H.R. 1443, but it would extend the readjustment counseling program for an additional 2 years.

Section 2 of both bills would authorize a new study of the needs of Vietnam-era veterans. The bill calls for the VA to transmit the conclusions and recommendations of the study to the Congress by December 30, 1984, in time for the subcommittee to act on those conclusions during the additional year of eligibility called for in section 1 of the bill. Only then will we have the tools to gage the strengths and weaknesses of the Vietnam-era veteran population. With that information in hand, we can review the requirements essential to the provision of these specialized services for the Vietnam veterans.

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[2] See p. 85.

Ten years ago this week the last American troops were pulled out of South Vietnam. Our direct participation in the war ended at that time. But it is still abundantly clear that, on this anniversary, that war and that conflict still rages in the minds of many who served in that war. It is our job to help them find the peace they seek.

The readjustment counseling program has been a unique success in providing compassionate health care in response to a direct need of the Vietnam veteran population. That, in itself, is the mission of the Veterans' Administration's medical program and the direct responsibility of this subcommittee.

I would now like to recognize the ranking minority member, the Honorable John Paul Hammerschmidt, for his opening comments.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. **Hammerschmidt**. Thank you, Mr. Chairman.

As you know, and many of us in this room know, the VA's readjustment counseling program had a rocky and difficult beginning. It came into being only after considerable controversy and considerable study. Its proponents thought it was needed as a vital adjunct to traditional VA medical programs. They believed that a large number of Vietnam veterans had readjustment and mental problems which would not be addressed unless a center approach was established.

Some of the opponents of the program were not sure that it was really needed. Many felt that necessary services could be provided in typical medical center settings. Some felt that many of the readjustment problems of veterans were not of a medical nature but concerned employment, marital problems, and events and situations not conducive to the kind of counseling to be provided and perhaps not readjustment problems at all. Of course, as there always is, there was the issue of cost.

The Congress considered and addressed the matter through intensive hearings and discussions and finally established the current program with a specific ending date. The Congress later determined that the ending date should be extended until September 30, 1984, with the final year to be used to assimilate the activity into the existing Veterans' Administration hospital system.

Mr. Chairman, it is possible there was some merit to each issue raised. Each was resolved in typical congressional compromise. The program had difficult beginnings, but in most instances is now working well. Some questions still remain. The program needs an ending date. We need to assure that the contract aspect of it is being administered in a proper fashion. We need to assure that the purposes of the center are being carried out, and that the readjustment centers, each of them, are aware that, like all the rest of the Government activities, must conform to necessary management controls with respect to such things as personnel rules, budgeting, administration, and supervision.

Having said that, Mr. Chairman, I have assured myself that this program has proven its worth. Its clientele have received a needed service that probably would not have been otherwise received. It has solved many problems, but there is much left to do. Accordingly, I find merit in your proposal to extend the program for 1 additional year and your proposal to make a comprehensive study of the prevalence of posttraumatic stress disorders and related readjustment problems among Vietnam veterans.

I have some concern, however, Mr. Chairman, with the timeframe in which the study results would come to us. I feel the VA might have a very difficult time in meeting the date of December 31, 1984. Therefore, in some anticipation of the passage of H.R. 1443 or a similar bill, which I understand the VA and administration favors in principle, I would hope that VA would immediately begin preparation of the study and assign a priority to it.

Mr. Chairman, I congratulate you on your initiative on H.R. 1443 and for scheduling this hearing, and I look forward to hearing the testimony of our witnesses.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you very much for your opening statement. Are there additional comments? The gentleman from West Virginia.

Mr. STAGGERS. Mr. Chairman, I really don't have any comments, but I do have to leave early because of other commitments and I did want to inform you that I do support your bill and I applaud you for your efforts in this area.

Mr. EDGAR. Thank you very much.

Are there any other opening comments?

Mr. EDGAR. Our first witness this morning will be Dr. Lawrence Kolb, distinguished physician in psychiatry from the VA Medical Center in Albany, N.Y. Would you come forward to the witness table at this time. We welcome you here.

We thank you for coming this morning and we look forward to your testimony. We understand you have an audio-visual presentation that you're going to share with us.

STATEMENT OF DR. LAWRENCE KOLB, DISTINGUISHED PHYSICIAN, VA MEDICAL CENTER, ALBANY, N.Y.

Dr. KOLB. Thank you.

During the past 5 years in my present position I have been actively involved in the diagnosis and treatment of the combat veterans of the Southeast Asian conflict who suffer the posttraumatic stress disorder. Most of this work has been carried out within the medical center. I have also consulted at and instructed the staffs of some 30 other VA medical centers and presently consult at the local Outreach center.

During this period of time I have personally examined about 140 men with this condition and have about 50 percent of them in treatment myself, the rest being cared for by colleagues. The treatments are individual and group therapy and the use of pharamceuticals. As a result of this work, the hospital which did not have services for this condition now offers a number of group sessions, three, not only for the men but for the wives and girl friends. We have established a psychophysiological laboratory for a certain kind of diagnostic screening.

Let me state that even now new patients continue to appear both in the medical center and in the local Outreach center. The latter offers both direct and contract services through a 20-county area in northern New York and western Massachusetts. The load of patients in continuing care has expanded each year and continues to grow in both the outreach center and the hospital.

As mentioned, my personal experience is largely hospital based. My patients have been found on medical and surgical services as well as on the various in- and out-patient psychiatric units, including the alcohol rehab unit. The majority of the men admitted to hospital inpatient services with this condition are socially more seriously maladapted than those in outpatient services or seen at the Outreach center. Many have suffered physical wounding during the conflict, but not of a major mutilating variety. Only about 5 percent have major dissociative states—commonly known as flashbacks, about which I will say more in a moment. In such conditions they violently reenact some combat scenes in public. Often such threatening behavior has led to their arrest and detention. Fortunately, none of the men seen by me have brought serious harm to others. Many have been unable to hold jobs, have been divorced, or have isolated themselves socially or through alcohol abuse. We have seen only two with hard drug habits.

I came to this work from experience during World War II, treating men in both the Pacific and Atlantic theaters who had the acute symptoms of the condition. We then used very successfully for such conditions a treatment called narcosynthesis, the injection of sodium amytal, and the suggestion that the man was back on the battlefield. This led to a violent emotional aberration, acting out, and the reduction of serious stupors, confusional states, paralysis, and various tics and agitation.

Later on in civilian practice at the Mayo Clinic and at the Columbia-Presbyterian Medical Center I have seen many other acute cases as a result of auto accidents, as well as the survivors of concentration camps and the victims of explosions, hurricanes, floods, and so forth.

We have statistics that the frequency of the occurrence of post-traumatic stress disorder directly relates to the occurrence of death and wounding in the combat units. We do not have good figures on the numbers of men who fail to recover from the acute phase and go on to develop the chronic and delayed forms.

My own work with the hospitalized men severely disturbed with major flashbacks and panic attacks seems to confirm an opinion held by an older psychiatrist who studied the chronic states from World War I. He suggested that these men had a physiological disturbance. Using narcosynthesis to initiate treatment in 18 men who had serious flashbacks, we found that 14 under a light barbiturate narcosis, when exposed to a short train of meaningful combat sounds, immediately returned in time to a combat scene and acted out that scene.

Furthermore, when they were exposed to a similar stimulus in a fully conscious state, they had marked rises in blood pressure, in heart rate, and muscle tension. These studies indicate to me a lowering of their perceptual capacity to threatening stimuli reminiscent of combat, inappropriate physical arousal, incapacity to maintain attention, and a tendency toward neurologically determined explosive behavioral responses.

They also show that these men are at very high risk for psychological dissociation when under the influence of any mind-altering drug, such as alcohol.

For the past 6 months my colleagues and I have treated such symptoms with adrenergic blocking agents, believing that there was a physiological defect and have had very good results from such. In my opinion, there is a need to continue to strengthen the treatment facilities for these men in the medical centers and the Outreach centers to improve the working relationship between the two and to support vigorously new research efforts related especially to the chronic and delayed forms.

I have with me the first of a series of televised narcosynthetic reactions. In this particular case we were using World War II sounds over a long period of time, and now we know that we only need to use 30 seconds of Vietnam sounds at very low intensities to produce a similar reaction.

I believe, as you look at this tape, you will become convinced of the existence of a serious emotional disturbance.

A word about this man's history. He was a helicopter pilot in Vietnam and in many actions. He lost his two buddies. He is a college graduate. He stayed with the Air Force because he was unable to adapt outside on returning to this country. Then in the year preceding his appearance at our hospital, transferred from the Air Force hospital, he turned up in the hospital suffering from pain in his chest, palpitations, sweating, believed to be some cardiac problem. None was discovered.

Finally, he exploded emotionally in an officers' club and attempted to attack a noncombatant officer who had insulted him and broke up the club.

He was then sent to the psychiatric service where I believe a misdiagnosis was made because he responded to a question about hearing voices. He was labeled schizophrenic. The man certainly is not, as you will clearly recognize here.

We televised these aberrations because the man has no memory of it and it is my wish to have a record so that they can be confronted with their inner selves, and the old technique has been modified by using combat sounds.

Incidentally, if there are some Vietnam combat veterans in this room, they may feel emotionally distressed in looking at this.

All that one may surmise as to the combat neurosis is contained within the agony expressed in this fine man's intense, emotional 20-minute abreaction.

May we have the TV tape?

[Illustrated by an audiotelevision presentation of a narcosynthetic treatment—the script follows:]

TRANSCRIPT OF AUDIOTELEVISION TAPE

NOTE.—T=Therapist; P=Patient; Italics=Observed Behavior.

Playing Audiotape. Cambat Sounds. *P grimaces. Covers eyes with left arm and turns away.*

T=Where are you now, do you hear anything? Where are you now? Tell us. Where are you Cardboard? What's going on? Are you at Bo Dak? Are at Bo Dak? What's happening? Tell me what's happening. What's going on?

Cardboard what's happening.

P=*Starts to cry. Turns.* Don. Don, he's dying. Don.

T=Tell me.

P=Don, Don. *Crying and sobbing.*

T=What's happening to Don?

P=He's dead.

T=What happened?

P=Got killed. Got killed.

T=How did it happen?

P=You know.

T=No I don't. Tell me.

P=This airplane crash. He was shot down.

T=He was shot down? What's he look like?

P sits up. Sobs involuntarily. Cries with tears.

P=Look at him. Look at him.

Silent period for about 3 minutes.

T=You can lie down now. It's just a dream. Lie down and go to sleep now. Do you know where you are now?

P sits up. Pounds table violently with hands. Sobs and cries. Clenches hands. Shakes bowed head slowly from left to right.

P=He is dead. Mac's dead. Mac's dead. Mac's dead. Don.

T=You can wake up now. You're just dreaming now. It's all over. It was a long time ago. How do you feel now?

P=Down.

T=What?

P=Kinda down.

P now seems more responsive. Lying quietly. Wipes tears from eyes with left hand.

T=Do you remember what happened?

P=No.

T=You don't remember?

P=Shakes head no.

T=You'll feel better in a little while. When you want to get up you can. You can't remember a thing about what happened? Are you able to talk now?

P=*Nods head yes.*

T=Do you want to talk?

P=Yeah.

T=Want to go on that picnic?

P=Yeah.

T=You remember that? I think we're gonna make it.

P=Good. What did I say?

T=What did you say?

P=Yeah.

T=You said, "Don, Don, He's dead."

P=That's my buddy.

T=Your buddy.

P=He and Mac were both my buddies.

T=Haven't had any buddies like them since.

P=Never will.

T=Never will.

P=No, never will. The war's a hellish thing.

T=You never went to see their families?

P=Never.

T=Why was that? What was the reason for that?

P=*Sobs deeply. Wipes tears from eyes.* Because I'm still alive!

T=You felt guilty?

P=Yeah.

T=You don't have a family?

P=No.

T=You have been spending all these years feeling guilty. Is that right? Is that the way you have been feeling?

P=Yeah.

T=It should have been you instead of them?

P=*Sobbing.* Yeah. Why not. I don't have nothing to lose. I don't have nobody. Nothing but a wife. They had 2 little kids—both of them. They called me Uncle

Willie—both of them. What am I gonna tell their kids when they ask me where their daddy is and what for—not a damn thing.

T=But you didn't do it.

P=*Crying.* They went because I went. I might as well did it.

T=They joined up because you did?

P=Yeah.

T=And you volunteered?

P=Yeah. I volunteered to go and they went and followed me.

T=And when you volunteered what did you think?

P=I heard they were short of engineers and I could help. *Tears.* The only way I helped was to get them killed.

T=But you couldn't know that. It could have been you.

P=I wish it had been.

T=You've been thinking that for 10 years. How many more do you think you'll have to think that?

P=I don't know.

T=You are making yourself suffer and I think you have had enough. That's what this is all about. You have a big conscience. We're gonna talk about this again and I'll show you what happened.

Dr. KOLB. I think the tape speaks for the condition. You saw here a response to startle, a flashback to a combat scene, and the successive reactions of fear, indignation, sadness, and guilt—survival guilt.

I would like to say he had panic attacks beforehand and yet for many years maintained quite a good adaptation in the Air Force.

I am pleased to state that as a result of the treatment he has received he is now back at work, has recently been promoted to a supervisory position, and is also in college studying computers.

Mr. EDGAR. The full text of your statement will be made a part of the record at this point.

[The prepared statement of Dr. Lawrence Kolb appears at p. 89:]

Mr. EDGAR. Dr. Kolb, I would like, on behalf of the rest of the members of the subcommittee, to thank you for bringing the audiovisual presentation along with your testimony. It did, in a few minutes bring into clear focus the kinds of problems that we are faced with here concerning the reaction to the Vietnam-era involvement. You are to be commended for not only your statement but for assisting the committee in bringing that audio-visual presentation.

Dr. KOLB. I want to thank my patient for allowing me to do it.

Mr. EDGAR. Let me ask you a couple of questions and then we will proceed to the other members of the committee for questions.

As you know, the current law requires the VA to begin phasing in readjustment counseling services now provided at the storefront vet centers within the structure of the existing VA mental health services on October 1, 1984, just 18 months from now.

In your professional opinion, given the background and knowledge that you have of the VA system, is the VA able enough or responsive enough to accept this mission and the client-load of the Vet Centers within this particular timeframe of 18 months?

Dr. KOLB. I do not feel that it would have cared for these men properly if the program were terminated within that period of time. Many of the problems of these men require continuing care over a sizeable period of time and there are still many men who are turning up at the outreach centers as well as in the hospitals.

Mr. EDGAR. In your professional judgment, how long would it take for the Veterans' Administration to be able to take care of this job within the framework of the mental health aspects of the Veterans' Administration?

Dr. KOLB. I would think it would be impossible to consider a termination in less than 5 years, at a minimum.

Mr. EDGAR. Would you consider the treatment and counseling function at the vet center program as being in the area of preventive medicine?

Dr. KOLB. Both preventive and therapeutic.

Mr. EDGAR. In what ways did we fall short in not addressing this problem within the World War II and Korea-era veterans population?

Dr. KOLB. I think in many ways those groups of men had an opportunity for debriefing and returned to this country and had a reception by their fellow citizens that prevented much of the problem that we now see amongst the Vietnam veterans. We saw very few of the delayed responses, although that was known, amongst those groups.

I would like to state, however, now with the new sensitivity about the post-traumatic stress disorder [PTSD], we are finding a sizeable number of patients in the World War II and Korean groups that were not recognized, at least in the hospitals.

Mr. EDGAR. Do you think the problem exists within World War II and Korea-era veterans?

Dr. KOLB. No doubt about it. There is writing in the psychiatric literature about it.

Mr. EDGAR. What, in your professional opinion, has been the human cost and the impact on the VA medical system from the oversight of not dealing with this issue?

Dr. KOLB. Well, I think one can only make some general statements. In my experience in the hospital where I work, there are a sizeable number of men with this condition unrecognized, being treated, perhaps somewhat inappropriately, on medical and surgical wards and even in psychiatric wards. In other words, there has not only been the provision of ineffective treatment for the man, but also uneconomic treatment provided by the system.

Mr. EDGAR. Could you summarize for the committee what are the problems of care of the Vietnam veteran who has post-traumatic stress disorder within the VA medical system? What are the specific problems concerning the availability of treatment?

Dr. KOLB. I think the first major problem is a recognition of this condition. After each war we seem to forget about its existence and we know very little about the chronic forms and even less about the delayed stress because those were not detected before. I am not sure that the total problem comes from the Veterans' Administration system. I suspect a sizeable amount of it must be placed on the educators in the field of medicine and psychiatry and mental health who failed to attune those coming to the field with a recognition of the problem.

Within the system the problem has been to assimilate and absorb these men into preexisting treatment regimens which have been given over to many other serious mental illnesses or even the social problems seen in the outpatient departments.

Part of the problem has nothing to do with the Veterans' Administration. It has to do with the attitude of many of the veterans themselves—as a matter of fact, the very attitudes which led to the establishment of the outreach centers. Many of the men have been so disaffected and felt so betrayed by the way they were received when they returned to this country that they have not in the past voluntarily come forward.

I think that is changing, both through the use and the availability of the Outreach centers and in increasing trust in the hospital care, a portion of which is due to the referrals to the hospitals from the Outreach centers.

Mr. **Edgar**. Thank you very much.

Mr. Hammerschmidt.

Mr. **Hammerschmidt**. Dr. Kolb, we thank you for your fine testimony and your presentation this morning.

Did this patient on the audio-visual come to your attention through a center or through the hospital?

Dr. **Kolb**. It came to my attention through the skill of a medical student who saw me interview another patient on a medical ward. This patient had been admitted to the psychiatric service with a diagnosis of schizophrenia. The medical student, after observing what took place with a previous patient, advised the psychiatrist on that service and also myself that he felt this man had a post-traumatic stress condition and should be treated for such.

That is the great value of having young people around who are so eager and interested in new things.

Mr. **Hammerschmidt**. That occurred in a hospital?

Dr. **Kolb**. That occurred in a hospital.

Mr. **Hammerschmidt**. And this treatment we were seeing on the screen was in a hospital setting, is that right?

Dr. **Kolb**. It is in a hospital setting. Such people are turning up in the Outreach centers. I now attend the local Outreach Center twice a week, where the chief of that center and his associates pick up peopie that they feel are seriously disturbed and oftentimes they bring them right down to the hospital to my office or to other offices.

Mr. **Hammerschmidt**. So to receive enduring benefit from this narcosynthesis——

Dr. **Kolb**. We only use this treatment for a very limited number of cases, with the serious flashbacks.

Mr. **Hammerschmidt**. But to receive enduring benefit, as I read some of your papers here, then you may show that to people that the patient wishes it be shown to, for instance their wives or their family——

Dr. **Kolb**. Yes.

Mr. **Hammerschmidt**. So that they will have a better understanding of what has happened to them.

Dr. **Kolb**. That is correct.

Mr. **Hammerschmidt**. Does that particular showing occur in the center or the hospital, usually?

Dr. **Kolb**. We usually do it in the audio-visual laboratories of the medical center. The Outreach center does not have those facilities.

Mr. **Hammerschmidt**. I was trying to determine how the hospital and the Centers interface in this particular type of therapy.

Dr. **Kolb**. I think we have a good relationship between the Outreach Center in the capital district and the medical center there.

There have been problems here and there across the country as I have heard it, depending on the sensitivity of the staffs in the two areas.

Mr. HAMMERSCHMIDT. Thank you, Dr. Kolb.

Mr. EDGAR. Dr. Rowland.

Mr. ROWLAND. Thank you very much, Mr. Chairman.

I compliment you on this excellent presentation, and the visual part was particularly enlightening. I have had an opportunity to use sodium pentothal in a similar manner with World War II and Korean veterans and know that it helps relieve or remove the barrier that exists where they have suppressed these most unpleasant memories. It is manifest in different ways over a period of years, this suppression.

I think it is just really great, Mr. Chairman, that you have introduced this legislation that is going to look more into this particular area because the Vietnam veteran had a unique situation. They were rejected and consequently did not want to say anything about what was really bothering them, although in fact he didn't really know what was really causing the problems that he was having. So I am just delighted that there are great strides being made in this area.

I am also pleased to know that this particular technique is still being used and is very successful. Once the pressure is removed from the subconscious, it gets out into the open and the person is able to talk about what is bothering him, and very frequently that relieves the pressure and he is able to function well again.

Thank you so very much for this excellent presentation.

Dr. KOLB. Thank you, sir.

Mr. EDGAR. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Kolb, I, too, certainly am grateful for your presentation and for that film.

For a long time now I have been trying to get clear in my mind what this war was really like, why was it so different, why has it had this type of an effect. Maybe it hasn't had any different type of effect; maybe we just weren't aware of similar things after the prior wars.

You testified that you had treated World War II vets. Was this as a Veterans' Administration physician?

Dr. KOLB. No. I was in the U.S. Navy. I was aboard a hospital ship on both sides of the continent, in Europe, and also in the Philippines.

Mr. BILIRAKIS. Would you consider yourself as having had as much exposure, experience and whatnot, with veterans of the Korean and World War II wars as you have had with the Vietnam war?

Dr. KOLB. Yes, indeed, for World War II. I have seen relatively few Korean veterans, but I have seen some.

Mr. BILIRAKIS. This guilt feeling, I have heard of it before and I have seen it before in Outreach centers and at civic association meetings, where we have had speakers and whatnot. Did we have as much of this for post-World War II?

Dr. KOLB. I think we certainly had as much in terms of the acute cases. What is remarkable about the Vietnam experience to me, and probably to many of you, is the occurrence of these delayed cases. I think some of the reasons are the failure of the men to be brought home in units, the exposure of these men to the dreadful situation that existed in this country when they returned home. Many of them were terribly treated by people in their community. The inadequate debriefing, there was no chance for them, as we say psychologically, to work this through. So there occurred a sizable amount of personal doctoring, either by retreating into their own selves and their own minds, or trying to wash it out with alcohol or even taking drugs.

What has taken place more recently is the occurrence of a series of either family events or even international events which have led to a rearousal of the intense emotional state.

For instance, I have seen a number of men who blew up as a result of the way this country managed its affairs in Iran around the hostage question, leading these men to feel once again that they had been ignored and displaced whereby a much smaller group of persons were lauded and made heroes. I have seen several people who had serious flashbacks after that.

Mr. EDGAR. Would the gentleman yield?

Mr. BILIRAKIS. Certainly.

Mr. EDGAR. In recent years there has been growing support for the Vietnam era veteran. After the period of the hostage situation in Iran and their return, the Nation responded, for instance, by establishing a Vietnam Memorial here in Washington. Throughout the country veterans' organizations began to have ceremonies honoring Vietnam-era veterans.

Are you able to measure any pattern that on the one hand there are probably more who are coming forward with the kind of trauma and stress because of the honoring of the hostages, but I wonder if, on the other hand, we are not also, with the vet center system in place giving a sense of pride in the minds of some of the veterans which they lacked 10 years ago.

Dr. KOLB. I feel this has been most important, that the country finally honored their efforts in this way. It has stirred up emotions in some, but many others are deeply appreciative.

Mr. EDGAR. I yield back.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

You have seen, then, an improvement in some of these patients as a result of this national feeling that we now finally have shown them?

Dr. KOLB. Yes, I think there is a change.

Mr. BILIRAKIS. And how long has this particular patient been a patient of yours, Doctor?

Dr. KOLB. He is no longer a patient of mine. He doesn't need me. He sees me occasionally as a friend. And he is not on medication now. I saw him first 4½ years ago, the second person I saw.

Mr. BILIRAKIS. And he had gone through quite a period of time before you saw him?

Dr. KOLB. Yes. He was one of those people who took a socially-acceptable course. He became a workaholic, but when he proceeded to be insulted and frustrated by some noncombatant people, he commenced to have these panic attacks and also the explosive violent rage.

Mr. BILIRAKIS. Would you say that this bill of Chairman Edgar's is adequate, extending this psychological readjustment period for 1 year?

Dr. KOLB. I would hope that it would go further.

Mr. BILIRAKIS. I think you testified a 5-year period of time was needed, did you not?

Dr. KOLB. Yes, sir.

Mr. BILIRAKIS. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. EDGAR. I would hope it goes further, too. Considering my bill, it is the first time I have ever been a "conservative." That's an inside joke.

The gentleman from South Dakota, Mr. Daschle.

Mr. DASCHLE. Thank you, Mr. Chairman.

I guess I would like to share in the accolades that have already been given about the presentation. It is rare that we get the kind of introspective view that you shared with us and I appreciate that. I especially appreciate the video tape.

I would like to take my line of questioning from the other side. I am not as concerned about the veterans in this particular case because I think we are making great progress there. I think with adequate treatment we are going to finally make some real headway. But I am concerned about the Veterans' Administration attitude, and I am concerned about the way this program is viewed from within. I am concerned about whether or not over the long period of time, whether it is another year or another 5 years, that the veterans can count on the VA to get the kind of care and attention that they need.

Let me ask you, first of all, Dr. Kolb, there is a requirement that I have before me that requires some kind of objective evidence be shown before a veteran can be treated. How rigid is that regulation applied to Vietnam veterans who come in? What kind of objective evidence do you or do you see other doctors apply to insure that veterans are provided with treatment?

Dr. KOLB. Well, the diagnosis in the majority of psychiatric or psychological problems is derived from history. You provide a series of questions to the individuals and you listen to and categorize their responses. We have in this area relatively little capacity to provide objectivity in the sense of biological tests or physiological tests.

One of the areas in which I am interested, I believe I have the potentiality with the new psycho-physiological test, the response to the sound stimulus, to develop a physiological assessment at least to indicate the degree of severity. I don't think every person with a chronic—in fact, I know they all don't respond to that in the same way. But a sizable number of those in the hospital do.

But that is the accepted objectivity used in my field for establishing a diagnosis, and I believe, at least in most of the hospital services, is used quite successfully.

Mr. DASCHLE. I have a memo here signed by Dorothy Starbuck. It says, "Objective evidence of a stress includes records indicating medals or commendations awarded for combat, or wounds suffered as a result of enemy action." It seems to me they are looking for something pretty tangible there. If I were a veteran who had no medals and who probably had no wounds——

Dr. **Kolb**. That's irrelevant.

Mr. **Daschle**. You're telling me it's irrelevant. Do you think that's a view shared within the VA?

Dr. **Kolb**. Well, I haven't read that document. I have seen people with post-traumatic stress and also other veterans who, indeed, have been decorated, but I have seen many who have not. You can get this condition without having decorations.

We generally ask that the man demonstrate through his service records that he has been in combat, his DD 214.

Mr. **Daschle**. We have a decision by an appeals board, and in this case they granted support to the veteran for post-traumatic stress. But then the last sentence concerns me a great deal. It says, the description of this event dealing with this post-traumatic stress predated the wide publicity of post-traumatic stress disorder and for that reason it's a bona fide claim. That really concerns me.

Are you seeing a difference in attitude by those veterans who come into the VA prior to the time—now, this patient happened to come in 4½ years ago. There wasn't much talk about post-traumatic stress then. What if a veteran walked in today? Is he looked upon much more skeptically as perhaps a victim of this disorder than one who may have come in prior to the adverse publicity?

Dr. **Kolb**. In the minds of some, I believe that is the case.

Mr. **Daschle**. Do you find the VA throws stumbling blocks in front of the veterans who come in and make claims to have this kind of disorder?

Dr. **Kolb**. I would speak about certain individuals in the VA who carry this skepticism, and I must say there are some peers of mine from World War II who carry this same skepticism.

Mr. **Daschle**. How widespread do you think it is? As a percentage, how many people do you think you can refer to in that kind of a situation?

Dr. **Kolb**. I don't know how many of the medical staffs and colleagues did not serve in the Armed Forces. If I knew that, I might be able to give you a projection. Those of us who were there know.

Mr. **Daschle**. My time is up. I could go on. But I think you have given us a real insight here and I am very grateful to you. Thank you.

Mr. **Edgar**. Mr. Penny, do you have any questions?

Mr. **Penny**. No, Mr. Chairman.

Mr. **Edgar**. Mr. Evans.

Mr. **Evans**. Dr. Kolb, I would like to know what would happen if the administration had its way and the vet centers were closed. Would we still maintain a high priority treatment for these kinds of disorders in the veterans' hospitals? Can you tell us, in your opinion, what would happen to the treatment of veterans with these kinds of problems?

Dr. **Kolb**. I think the people in the Outreach centers are sensitized to the problems of the Vietnam veteran. Having been around the country extensively, I can assure you that certainly in a number of the hospital outpatient services that sensitivity does not exist and also the staffing is not available. I would feel that a sizable number of these people would find themselves back in the isolated position they were in some years ago.

Mr. EVANS. Knowing that they would not have the sensitivity within the medical facilities, do you think the VA would continue to spend as much for the treatment of post-traumatic stress disorder?

Dr. KOLB. I'm sorry, I didn't quite get the question.

Mr. EVANS. Knowing that they would not have that sensitivity toward the treatment or diagnosis of people with post-traumatic stress disorder, would they spend as much time and as much money on the treatment of this problem?

Dr. KOLB. Would they——

Mr. EVANS. Right, in the hospitals?

Dr. KOLB. I would have some doubt about it.

Mr. EVANS. There is a center just outside of my district in Peoria, Ill., and I have many veterans from the Bartonville area that go to that center. If this center was closed down, and these veterans had to resort to the Iowa City, Iowa Medical Center, some 2½ hours away, do you think this would lessen the likelihood of treatment among these veterans? Do you see problems with this lack of availability?

Dr. KOLB. It would be a problem. Even now there is a problem due to the large area that many hospitals service, and I think the contract mechanism is one way, indeed, where you can take care of some of those people who live out in the rural areas.

Mr. EVANS. Thank you.

Mr. EDGAR. Thank you.

Mr. PENNY. Mr. Chairman, I do have one question I would like to ask the witness.

Mr. EDGAR. I yield to Mr. Penny.

Mr. PENNY. In your testimony you indicated that there were sessions available, at least in some instances, for the families of the victims of post-traumatic stress. Do we, under the counseling program that is available to veterans, do enough to also make counseling and services available to their families?

Dr. KOLB. I have some doubt that we do. As a matter of fact, in the hospitals at least, the counseling of the families has come about spontaneously through professional feeling. Some doctors have wondered whether they are charged to do so but they do it nevertheless, which I think is a good thing—doctors, psychologists, and other mental health workers.

Mr. PENNY. It seems to me that is extremely important. I got the feeling from the testimony that it was a rare occurrence when families were also counseled and assisted. I think we have to be more cognizant of the need in that area.

Mr. EDGAR. Perhaps the gentleman might want to take a look at the study which we have in both the Mica bill and the Edgar bill, and perhaps a third version of the bill, as to whether or not we extend for 1, 2, or 3 years. We hope to mandate a study and in that study we are looking at the impact on women veterans, the specific impact on Vietnam veterans, and I think we ought to include, either in the language of the study or in the report that accompanies that, the question the gentleman raises about the impact on families and family counseling within the system. My staff whispers in my ear that it is in the study. But we might underscore that in some report language.

Mr. Mica.

Mr. **Mica**. Just a couple of quick points, Mr. Chairman. I have to leave but I hope to return.

First, I would hope that there would be some way the record could point out some cases where we have averted problems, avoided problems, by having these programs available. I think a story that is probably known by this committee about me being threatened by a Vietnam veteran last year, 2 years ago, just because of not opening a center on time, and some of the life-threatening situations that have been avoided because we have had counselers in the field, ought to be made a part of the record. I hope we can get some of that information here.

As I understand it, when we were involved in the incident, there were cases like this on record all over the country, where Vietnam veterans were literally at the end of their rope, and the only thing that averted a catastrophe or a real crisis in a community with them going off the deep end was the availability of these centers. So I hope we can get that into the record and would appreciate you or anybody else who is going to testify to submit any information on this.

Second, I would like to point out that in a rare instance here of reversed roles I am the "liberal" as opposed to the chairman, and my bill does move for 2 years. But I think we would be happy to go for an extended number of years. Our only concern, I would estimate, within the committee and the Congress is how far we could go and get a reasonable bill passed. I am sure the chairman would be a little more liberal and support my bill. We have discussed this and are working together on this.

Finally, I don't think there is any question as to the need. I appreciate your being here. I think Mr. Daschle probably raised the most important questions that can be raised here today, as to how much of that need is recognized within the Veterans' Administration. We really need to have an emphasis on this, a direct emphasis, and the tapes you brought here today I think are most helpful.

Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you for your comments.

Miss Kaptur?

Ms. **Kaptur**. I have no questions, Mr. Chairman, but I just want to let Dr. Kolb know that I have read the testimony. I wasn't able to be here for the film. I just wanted to say how impressed I am with your work.

Dr. **Kolb**. Thank you.

Ms. **Kaptur**. I also am impressed with the fact that the individual that was filmed has permitted this to be used in a setting like this. He is performing a great service for this country. I just wanted to put that on the record.

Thank you very much.

Mr. **Edgar**. Thank you.

Mr. Richardson.

Mr. **Richardson**. Dr. Kolb, Mr. Chairman, I apologize for being late.

I would like to know, has the VA taken a position on the Mica and Edgar bills?

Dr. **Kolb**. I don't believe I can respond for the VA. I operate my own office and I am not at the policy level.

Mr. **Edgar**. If the gentleman will yield, the VA will be up here in a few minutes and we can ask that question directly of them.

Mr. **Richardson**. The reason I raise this, Mr. Chairman, is I first of all would like to cosponsor Mr. Mica's bill because I think it is critical that we maintain these centers. The reason that I would like to stress the need for my congressional district is the fact that my district in northern New Mexico is composed of 60 percent minority population—40 percent Hispanic and 20 percent native American.

New Mexico had the third highest casualty rate in Vietnam per capita. In my district we have 5,300 veterans. What I sense and what some of the veteran officials in my district tell me is that it is only now, this year, that some of those veterans of Hispanic and native American origin have started to come to the centers. They have stayed away for social and cultural differences. It is only now that they have gotten over the trauma of feeling the centers are, in essence, there to help. In my State, because of the very rural nature of my district, it is very difficult for veterans from my district to come to one of the centers, which is in Albuquerque, N. Mex. We have a satellite office in Gallup, which is mostly a native American area in the part of my district.

My concern is that at the time when Vietnam veterans of minority populations are first starting to come in and participate, that there is the possibility that, because of budget cuts and many other reasons, these centers are going to be taken out.

In talking to some of the psychologists in New Mexico, Dr. Kolb, they have told me that the treatment is different for members of Hispanic and native American origin. I wondered if you could elaborate for the record on this subject, whether this is the case. Are there any statistics to show that many of these minority veterans have been slow in participating in this program?

Dr. **Kolb**. I will be pleased to speak to that. This is an impression. Of course, I am working now in northern New York. What has impressed me is that, of the minority groups, the blacks came in after the whites, and then we have had—we don't have a large Spanish-speaking population, but we have some. Those people have come in last. They are very few in number. Furthermore, they have had great difficulty adapting to the treatment program that we have in the hospital.

I do think there is a cultural difference which makes them more, shall I say, disaffected and more suspicious of what is going on. I am not sure that the general principles of treatment are different for the groups, but I think there has to be a cultural factor in order to bring in the Spanish-speaking veteran.

Mr. **Richardson**. I would be very reluctant if the VA saw fit to phase these out. It just seems to me that we have forgotten the Vietnam veteran completely. We try to give explanations—I was back in my district this weekend, and I have introduced a bill, along with the gentleman from South Dakota and Mr. Edgar, regarding agent orange. They ask me, here we are bailing out a town that has dioxin problems, but we can't do the same for the Vietnam veteran. The psychological centers in my district, at the same time that we have the first acceptance of them, we are talking of phasing them out. I was going to propose having a satellite office in my congressional district, expanding the one in Albuquerque. But then, Mr. Chairman, I pick up the Washington Post and I read again the administration's favorite buzz words. They are talking about "cost benefits"; they are talking about "cost analysis." They talk about a task force urging the elimination of the VA hospitals. They talk about, I suppose, the issue of health care for veterans. I don't know where they would put it. Probably under the best cost management procedures they would put it under HUD.

Mr. **Edgar**. Would the gentleman yield? There is a rumor that they're going to put it under EPA.

[Laughter.]

Mr. **Richardson**. I think it would probably be better under HUD.

Mr. Chairman, it just seems to me—and, Doctor, I am not criticizing you. You have a tough job, and I can't be here when the VA is here. But my whole point is that we try to do something new that is justified, that makes sense, such as the counseling centers, which are critical in my district, which I said 60 percent is minority population, and then we are talking now about yanking them out. It would seem to me, if there was any commitment and compassion, that there would be an overwhelming support on the part of the VA for Mr. Edgar's bill or Mr. Mica's bill. Every day I get jabbed by the reality of—I am going to a hearing on the EPA right now, and I am going to hear about how we have to deemphasize the RCWP program on the guide of cost benefit.

It seems to me that the human side of our problems and those people at the VA that are dedicated are now going to be dismantled. I hope this task force report is not the case.

Thank you, Mr. Chairman.

Mr. **Edgar**. The time of the gentleman has expired.

Mrs. Johnson?

Mrs. **Johnson**. I have no questions, Mr. Chairman.

Mr. **Edgar**. Mr. Evans?

Mr. **Evans**. Mr. Chairman, for the benefit of the members of the committee, I am going to be introducing a bill to extend the outreach program for 3 years. Being a Vietnam era veteran, and having been impressed with the effectiveness of this program, I will be introducing this measure and I would ask the consideration of my colleagues for this legislation.

Mr. **Richardson**. Well, you have got your first cosponsor.

Mr. **Edgar**. I think it is only fair that if the chairman has a 1-year bill and Mr. Mica has a 2-year bill, you just add the 2 bills together and that comes up to 3 years.

I appreciate the gentleman introducing the legislation. I have to say that since introducing the 1 year extension, information that has been brought to my attention and across my desk is that we have to look beyond the 1 year for an adequate expansion of the program. I would like to commend the gentleman for his vision and looking at a longer term for this particular program.

I think we are discovering that there is an increase in demand, and we will hear from the VA, in terms of the number of people coming to the centers and the impact of the centers in local communities. For this reason the program should not be terminated as abruptly as we had thought earlier.

Mr. **Bilirakis**. Mr. Chairman, if I may, sir, on behalf of the committee, I would like to congratulate Dr. Kolb for having been designated a distinguished physician. I understand there are very few of you throughout America. Congratulations.

Mr. **Edgar**. Dr. Kolb, just before you leave, just for the benefit of the committee, would you define that term for us? Those of us not in the medical profession may not understand it. We could ask someone else to do that and it might make you feel better, but perhaps you could just let us know for the record what that term stands for.

Dr. **Kolb**. I have a facetious definition. It is called "displaced person." [Laughter.]

I think the Veterans' Administration has some 12 positions of this kind given to senior people—most of us are retired from academic posts—to act as a full-time, sort of a consultant to the Chief Medical Officer. I happen to be the person in the field of psychiatry. My colleagues are in the other medical specialties.

Mr. **Edgar**. Thank you very much. We appreciate your testimony and compliment you on your activities.

Mr. **Edgar**. Our next witness will be Dr. Arthur Arnold, Chief of Psychiatry Service, at the VA Medical Center in Phoenix, Ariz.

The next several witnesses will be professionals in the field. We will not be able to take the kind of time that we took with Dr. Kolb with each of the witnesses or the hearing will go through dinner.

Dr. Arnold, your full statement will be made a part of the record. We thank you for coming to the committee this morning and we invite you to proceed as you see fit.

STATEMENT OF DR. ARTHUR L. ARNOLD, M.D., CHIEF, PSYCHIATRY SERVICE, VETERANS' ADMINISTRATION MEDICAL CENTER, PHOENIX, ARIZ.

Dr. **Arnold**. Thank you, Mr. Chairman, and members of the subcommittee.

I knew very little about the effects of combat stress on Vietnam veterans before 1979, when I began learning about this from patients. Then when one of the first VA Outreach programs opened in St. Petersburg, I invited their staff to discuss with us what they referred as delayed stress syndrome. Later we learned from invited speakers, including Dr. Blank and Dr. Kolb with his video tape, on the diagnosis of post-traumatic stress disorder and the nature of the Vietnam war. Despite this training and the fact that the American Psychiatric Association published a revised diagnostic system with a detailed description of PTSD, and a clear clinical statement issued by Dr. Jack Ewalt to the VA medical centers describing PTSD as it applied to Vietnam veterans, most senior clinicians on our staff had reservations about posttraumatic stress disorder, or rejected the concept entirely. Many of them still do.

But a few who are more recently trained were able to work well with Vietnam veterans and were good at diagnosis and treatment. When Vietnam veterans on the psychiatric wards became more resentful at what they saw as rejection by the staff and inappropriateness of psychiatric treatment, I asked the interested staff to plan a specialized program.

In May 1981, 20 of our 96 acute psychiatry beds were utilized for the treatment of Vietnam combat veterans with PTSD.

No new or special staff or space was available. The program was specific for PTSD. The treatment mainly is to talk out the experiences, particularly those causing guilt feelings, which were overwhelming, and to gradually come to terms with them, individually or in a group.

In a specialized unit, something else important happens. The men form a close bond with each other, confronting problems openly, but also supporting one another with deep caring through difficult times. We described our program in detail in a program manual.

The program is one of the most difficult and yet one of the most rewarding professional experiences anyone could have. The stress on the staff is high and burnout is a constant hazard.

We encountered a number of problems, which are still not solved. The length of stay is long, usually several months, and there is a long waiting list. The sharing of space with general psychiatric problems results in border clashes. The veterans demand medication to ease their pain, but working through the stress requires them to get a minimum of medication.

There are a number of readmissions of men who seem to be doing better. There is an almost universal need for vocational rehabilitation but a lack of ability to respond. It is essential to deal with PTSD on both an inpatient and outpatient basis, coordinated with vet centers and alcoholism units, and these are usually organizationally fragmented.

A specialized unit for veterans populations so difficult to treat could not be set up and function without strong administrative support. The Chief of the Psychiatry Service has to be knowledgeable and take the initiative to bring the various professional staff together and to produce a sound program. The Chief of Staff and the medical center Director have to be actively supportive for the program to survive in the hospital atmosphere of competing priorities and interests. It also helps to have the support of the Mental Health and Behavioral Sciences Service in the Central Office.

There are now eight specialized treatment units for Vietnam veterans with posttraumatic stress disorder in VA medical centers. Except for a 90-bed unit on the west coast, they are all in the eastern half of the country and range from only 12 to 26 beds. Only the Menlo Park and Bay Pines units have operated more than a year. All have used existing staffing, have very similar treatment programs, long waiting lists, have difficulty arranging for outpatient follow up, and work as closely as possible with the nearest outreach program.

The working relationship with outreach staff is essential. Most Vietnam veterans approach vet centers more freely, and if hospitals are responsive, veterans who really need it can be transferred for treatment. The vet centers staff have made some heroic rescues of Vietnam veterans to get them to the hospital. They provide a support network which helps veterans survive in the community.

Vet centers are seeing more difficult cases now. The mental hygiene clinic workloads are way over capacity, so there is no easy solution to outpatient treatment of PTSD when hospitalization can be avoided.

We need to learn more about PTSD. Particularly, we need research on what makes specialized treatment units effective, brain function in anxiety and sleep, and the relationship between kinds of combat stress and groups of symptoms.

From the perspective of a psychiatrist in the field, posttraumatic stress disorder is almost unique among all the psychiatric conditions we treat because it is so clearly related to combat exposure. These are truly wounds of war, and in psychiatry it would seem to be a particular responsibility for those of us in the Veterans' Administration.

Thank you for your attention.

[The prepared statement of Dr. Arnold appears at p. 100:]

Mr. **Edgar**. Thank you very much.

You say these are the wounds of war. Someone once said: "In war there are no unwounded soldiers." I think in the vet center program we are discovering there are, in fact, many people who do not have casualty marks to show from battle but, in fact, mentally continue to have real stress. I really appreciate your focus on that.

On page 5 of your testimony you state "The sharing of space with general psychiatric programs results in frequent border skirmishes." Then again on page 3 of your testimony you state, "A number of senior clinicians on the staff frankly expressed reservations about PTSD, or rejected the concept entirely."

Does this attitude still exist within the Veterans' Administration and, if so, how would this affect the ability of the VA to provide the veterans outreach programs, in-house?

Dr. **Arnold**. In discussing the experiences of treating Vietnam veterans with colleagues who are operating some of the other specialized units, I get the impression that it is a common experience to find that members of the clinical staff—particularly those who have been trained in years past and who are old enough to be fixed in their thinking—have some difficulty dealing with new concepts like PTSD.

The attitudes of the staff very strongly affect the effectiveness of treatment for Vietnam veterans, who have so many mixed feelings about authority figures anyway, and so many disturbed feelings about themselves, that encountering people who are rejecting or cold or who clearly fail to acknowledge their pain and the facts of their clinical conditions, causes much more resentment and much more negative attitudes on the part of Vietnam veterans than with patients who have other conditions. It absolutely blocks treatment.

I think there are several effective ways to approach this. One of them is through clinical education. There have been a number of major sections of the scientific meetings of the American Psychiatric Association and the American Psychological Association dealing with posttraumatic stress disorder, and to some extent those should provide the information necessary for clinicians, including those in the Veterans' Administration, to be able to deal with PTSD more appropriately. But if the mindset is negative, it is very difficult to get the information across.

I can recall a couple of staff members who could readily, after training programs, diagnose posttraumatic stress disorder in Korean and World War II veterans, but who maintained that any Vietnam veteran who had ever used drugs or who had been unable to maintain a marriage or had gone from job to job or had had many of the other behaviors often associated with post-traumatic stress disorder, was simply an antisocial character or a drug addict, or in some other fashion a person who didn't require and shouldn't get psychiatric treatment.

Mr. **Edgar**. There are currently only eight posttraumatic stress disorder inpatient programs operating in VA hospitals throughout the United States. The VA currently operates 172 hospitals.

In your opinion, are these services sufficient to meet the existing demand from the Vietnam veterans population, and how many more programs or beds would have to be allocated to meet the need, in your opinion?

Dr. **Arnold**. First of all, while specialized units are effective and may be the best way, I wouldn't want to suggest that they are the only way to treat Vietnam veterans who have posttraumatic stress disorder on the basis of their combat experience. There are VA hospitals with staffs on their psychiatric services most of whom are able to recognize this condition and deal with it effectively.

I think in those situations, if there were a way to also facilitate the mutual support of the veterans, which is a very important part of the treatment, it would be possible to deal as effectively with Vietnam veterans as on specialized units. It isn't so much a question of additional beds as it is the imporvement of staff capabilities to deal with the situation.

The logistics in a hospital are also important. Where it is possible to demarcate a small ward, specialized treatment can be more readily accomplished than in hospitals which have very large wards and where small programs have to coexist with others.

Mr. **Edgar**. My final question relates to the fact that in the establishment of the eight programs that, in fact, do exist. Were these programs initiated by directive from the VA Central Office in Washington, or were they developed at the local level as a spontaneous reaction by concerned invididuals who sought to be innovative?

Dr. **Arnold**. I think it was some of both. They have been concerned individuals at various hospitals, and one of the factors stimulating their interest in better treatment of Vietnam veterans with post-traumatic stress disorder has been the training programs that have been conducted by the Mental Health and Behavioral Sciences Service in Central Office, on both the west coast and the east coast several years ago. Following these training sessions there has been a greater interest. The six or so units that have been developed in the last year clearly relate much of their impetus and their improved understanding of this condition to the training programs that the VA Central Office sponsored.

Mr. **Edgar**. Thank you very much.

Mr. Bilirakis.

Mr. **Bilirakis**. One quick question, Mr. Chairman.

Dr. Arnold, in your testimony you say that in May 1981, 20 of the 96 acute inpatient psychiatry beds at the VA Medical Center in

Bay Pines, Fla., were utilized for the treatment of PTSD. What were the other beds being used for?

Dr. ARNOLD. The general psychiatric program was being carried out on all 96 beds prior to that time——

Mr. BILIRAKIS. I appreciate that, yes. I am trying to get the specifics.

Dr. ARNOLD. The other units continue to provide general psychiatric treatment.

Mr. BILIRAKIS. Might some of those be used for general psychiatric treatment for non-service-connected problems?

Dr. ARNOLD. There is a mix of service connected and nonservice connected veterans in the units, of course.

Mr. BILIRAKIS. There is a mix in the psychiatry unit; is that what you're saying?

Dr. ARNOLD. True.

Only a small proportion of Vietnam veterans with posttraumatic stress disorder are service connected. This appears to be related to the difficulty in making understood the clinical findings of posttraumatic stress disorder as clearly for service connection evaluation as can be the descriptions of other, more classical common psychiatric conditions—schizophrenia, depressive disorders, and so on—that are better known and more easily understood for compensation purposes.

Mr. BILIRAKIS. Do you find there are many instances of Vietnam veterans with possible PTSD who are not getting the proper precedents and the proper attention in terms of being admitted, and that these beds are being used by many veterans who possibly may not have quite the same need?

Dr. ARNOLD. I don't believe in any of the hospitals where I have been responsible for the programs that this has been the case. All of the admissions regardless of diagnosis have been based upon a clinical need, and usually because there are no excess beds, it is on the basis of some emergent situation. A person who is schizophrenic, and is a suicidal risk, is just as much in urgent need of admission as a Vietnam veteran who is a suicide risk.

I couldn't say there are inpatient beds that are being used for the treatment of conditions that are less serious. It is more that there are other impediments to the admission of Vietnam veterans. Many of them can't go through the hassle of the admitting office unless, as we did, arrangements are made with the vet center staff to expedite that process. Very often a member of the vet center staff would walk through the admission process with the veteran right from the front door of the hospital to the ward. Some veterans who anticipate trouble in the admitting process won't approach the hospital.

Mr. BILIRAKIS. Thank you, Dr. Arnold. I thank you, sir, for complementing so very well Dr. Kolb's testimony and for having served as chief of psychiatry at Bay Pines. It is one of the hospitals in my area there in Florida. Thank you, sir.

Dr. ARNOLD. Thank you.

Mr. EDGAR. Thank you.

Mr. Evans.

Mr. EVANS. Dr. Arnold, do you think that the past estimates of post-traumatic stress disorder within the Vietnam-era veteran population has underestimated or overestimated the severity and extent of the disorder problem?

Dr. **Arnold**. I think more recently, and particularly among staff who have worked with Vietnam veterans fairly intensively, there is a much more accurate assessment of the severity of the need and the likelihood that it is going to be fairly longstanding for a number of the ones who are the most seriously disturbed.

It came as a rather unexpected finding to us that Vietnam veterans who have appeared to progress very well, after a month or two of fairly intensive treatment, were readmitted later with symptoms which were just as severe. I can give you an example.

There was a fellow who improved very well, apparently, who was shot in a robbery where he worked. This experience re-evoked all of the symptoms that he had experienced earlier with post-traumatic stress disorder.

We should have expected this, I guess, because I can remember one patient particularly who was a POW in Corregidor who had been, after discharge from the service, granted an award as the outstanding civilian employee of one of the Armed Forces, who had a very severe recurrence of post-traumatic stress disorder symptoms nearly 40 years later, when a man who had been his buddy in the prison camp suicided. His symptoms were very much like the ones we have seen in Vietnam veterans, and this was many years later. So I would expect that there will be some underlying potential, or vulnerability for serious recurrences that may continue for a very long time for Vietnam veterans.

Mr. **Evans**. You indicated in your testimony that there has to be active administrative support for a good environment within the hospital. Earlier, Dr. Kolb testified that he doubted that many hospital staffs would have that sensitivity.

Wouldn't this severely affect the ability of the VA to treat this disorder problem?

Dr. **Arnold**. Well, in every hospital there is a range of interests and capabilities. There are people who are particularly adept at treating alcoholism, and there are some who are particularly good at treating various other conditions. In almost every hospital there are staff—and I have found this to be the younger, better trained, and more openminded staff—who are able to treat Vietnam veterans. What is primarily required is the clinical and administrative leadership to bring those people together and to facilitate their learning what they need to do.

There will always be some members of the clinical staff who aren't particularly adept at this, but there are other useful things they can do.

Mr. **Evans**. You indicated also the problems of the veteran going through the check-in process at a hospital. Wouldn't you say this process would be further aggravated if the veteran had to drive 2½ hours simply to get to the center.

Dr. **Arnold**. It has been a difficult thing to get Vietnam veterans to get over any obstacle to get to a hospital, and distance is one of them. Two vet centers that I have known most closely travel into some outlying areas and help Vietnam veterans to come to their facilities. Sometimes they have gone long distances. In Florida they have gone out to backwood areas where veterans are living in isolation to help them to come in to get care when they learned of their great need. Distance is a serious obstacle, as it is for almost any service, of course.

Mr. **Evans**. Thank you, Doctor.

Mr. **Edgar**. Mr. Penny.

Mr. **Penny**. Mr. Chairman, I have no questions.

Mr. **Edgar**. Mr. Daschle.

Mr. **Daschle**. No. I'm sorry, I missed the testimony.

Mr. **Edgar**. Thank you very much, Dr. Arnold, for your testimony. We appreciate your continued interest and support in the vet center concept and also in the psychiatric needs of Vietnam-era veterans. We appreciate your testimony.

Mr. **Edgar**. Our next witness will be Mr. Craig Burnette, team leader at the vet center in Knoxville, Tenn. Mr. Burnette.

Thank you very much for your patience this morning. Your full text of your statement will be made a part of the record, and we invite you to proceed at this time.

STATEMENT OF CRAIG W. BURNETTE, TEAM LEADER, KNOXVILLE, TENN., VET CENTER

Mr. **Burnette**. Mr. Chairman and members of the subcommittee, I want to thank you for allowing me to come and share with this committee what the Knoxville Vietnam-Era Veterans Outreach Center has seen and is presently seeing since we opened our doors on January 9, 1982.

I want to depart from the written statement for just a moment, please. I would like to comment on the film that was seen first. I want to compliment Dr. Kolb on his work there. I would like to share with this committee that the emotions that the man was feeling, how he was getting in touch with what had been going on inside him for many, many years, is exactly the kinds of things that we see every day and every night in our vet center, either through individual counseling or group counseling.

Now, we do not use medical techniques like that, of course. We use standard counseling skills that our staff has been trained in and schooled in. Scenarios and scenes like that are exactly what are played out as we work with our vets day in and day out. I just wanted to emphasize that and I appreciate Dr. Kolb for bringing the film here.

When we opened our doors, we found very quickly that the veterans coming to see us were presenting multiple problems. They were experiencing dreams and flashbacks. They were anxious and fearful. Some of them were talking of suicide. They were concerned about agent orange, and they had no meaningful interpersonal relationships with anyone. They were angry and embittered, numb and isolated from the world around them.

They presented other problems—vocational, marital, financial, legal, and substance abuse. A large number of the veterans would come in, sit down and say "I simply want to talk to someone. I have never had the chance, and I have always wanted it."

Many of our veterans have gone a long way towards solving the problems they have brought to us, and many still have a way to go, and we are continuing to work as hard as we can with them. Attached to my statement that you have are some of the statistics we have gathered on our clients that we have seen thus far.

Please understand these problems I am addressing are just as real for each veteran we see today as when we opened, and they are rooted in the military experiences of our clients. I would like to describe how our vet center comes into play as we work with these veterans towards resolving these feelings about their experiences either in Vietnam or during the time they were in the military and the subsequent months and years after their military or Vietnam experience.

Working on these feelings is the essence of what we are doing at the center. We provide individual and group counseling, and we believe our rap groups are the strongest and most effective way of treating the problems that they present to us. We have always operated, since the day we opened, a minimum of three rap group meeting every week. The groups consist of our combat veterans, or era veterans, and the significant others.

The gentleman commented about family counseling, and I want to state that we do get the families involved at our vet centers. I have a 73-year-old mother participating right now in my significant others group. I also have a brother and some cousins. So we are working with the family nucleus as well as significant others.

In regards to our veterans, they are able to release many feelings in particular the anger and the anguish that they have held within them for so many years. They realize they are not alone, and that is the beauty of our groups. If I have heard one, I have heard 50 say, after hearing another veteran tell his or her story, "I thought I was the only one who thought that way or did those kinds of things." You see, vet centers are places where the Vietnam veteran can find security and trust and can be treated with respect and dignity, no matter what story is told, no matter what emotion is displayed.

It is tragic that they have had to wait until now to have this opportunity to talk. But with the exception of some self-help groups, the DAV project, et cetera, the vet center is the first place that has ever addressed specifically and systematically the problems associated with their military experiences.

This becomes even more obvious to me when I present workshops and presentations to mental health professionals who acknowledge through the years that they have never even considered asking a Vietnam veteran, if they're a Vietnam vet, and then ask them to talk about their military experience. That is exactly what we are doing with them at the vet center. We deal with their military experiences, that part of their lives that has been held down for so long.

Over 90 percent of our clients are incountry Vietnam veterans, and the majority demonstrate one or more of the criteria for post traumatic stress disorder. We found that what we see is not limited to a certain socioeconomic group, either. Our estimates are that 25 to 30 percent of our clients who are involved in long-term counseling with us and are displaying PTSD-like symptoms can be classified as white collar professionals with good, steady jobs and seemingly stable relationships. I believe these figures would be higher if some people didn't put a label on people who seek counseling help.

You would be surprised how many counseling sessions I do with some pretty top notch executives over lunch instead of at the vet center.

I would like to comment also on another way we impact on our veterans in our area. We call it networking and outreach. We do it by giving workshops and presentations to both the professional and the lay community. The last one I presented before I came up here was to a senior citizens group in Tazwell, to the north of us. These people on numerous occasions are interacting with Vietnam veterans, and our presentations are designed to sensitize them to the issues faced by our veterans and to impart some skills in working with them. We have given these presentations to service organizations, business, church and civic groups, high school and college classes, mental health facilities, legal groups and so on. We give radio interviews and make television appearances. We get publicity through our news papers. At present we are planning two large workshops in Nashville and Knoxville, Tenn., specifically looking at PTSD, and we are bringing in a national expert on that issue. We are doing this, by the way, through the University of Tennessee at Knoxville so it is not going to cost the Veterans' Administration anything. We set that up through a source that I had at UTK.

As a result of this networking, many Vietnam veterans are referred to us for help and, in turn, we refer our veterans out to the agencies who can help them. I believe our community sees the vet center as a positive force working in conjunction with it to effect real change in our clients. For instance, we run a substance abuse group that serves for some of the community agencies as an aftercare program for the Vietnam-era veterans who are their clients.

We have also been responded to by the community through volunteers, i.e., university students who want to co-lead in our groups—people who want to spend some time in the office helping us with the phone, et cetera. It is a result of this networking that we have had plenty of contact with our veterans, but we find that over 90 percent of the veterans coming to us are within a 40-mile radius, Therefore, we need more time. and more staff to go out in the hills and mountains of east Tennessee and establish satellite centers, if possible, where we know there are large populations of Vietnam-era veterans.

At present we are making a very special effort to outreach, find, and bring in women veterans. One of the persons on my staff has specifically started networking for this program, and we hope to have a group exclusively for women veterans within the next month. This personally strikes home to me as my wife is an in-country Vietnam veteran who served with the 24th Evac Hospital in 1968 and 1969.

Regarding our work with other Veterans' Administration facilities, our vet center is approximately 150 miles from our Nashville Medical Center, which is our parent facility, and 130 miles from the Mountain Home Medical Center. We have used these and other medical centers extensively in treating our clients. Locally we have a Veterans' Administration Outpatient Clinic. The Chief Medical Officer there, Dr. Howard, has stated on several occasions how his problems have lessened since we opened our doors.

In the 14 months we have been in operation, we have seen approximately 700 veterans and have recorded over 2,400 visits by them and their significant others. We believe these numbers will continue on and increase as word of our existence spreads even further. We believe this will occur because of our own professional and personal commitment, and because of the veterans themselves. I believe if we cease to exist, we will cut off from any help a population that only a program designed like ours can reach.

I must state at this point that I believe for this program to continue to be successful, it must remain nontraditional in style. We must have flexibility in our work hours. We must continue to be allowed to go where the veteran is. We cannot get bogged down in all kinds of paperwork, taking away from us the most important ingredient that we have to give to our veterans—time, the time to listen and deal.

We must continue to have staffs who are professionally and personally committed and who possess the empathy and energy necessary and needed to deal with the type of clients we see. We cannot be seen as just another bureaucracy with the attending red tape and hassles. We must respond to our veterans like soft earth to rain as we accept and hold them and not like some concrete sidewalk that the rain bounces off of and runs away.

I am going to close by sharing with you a story that I believe tells what our existence is all about. It's a very short statement. On January 14, 1983, a Vietnam veteran, ex-marine, stood before approximately 100 people as we celebrated our 1st year anniversary. He had been coming to our vet center and attending one of our rap groups for about 3 months. He had come to the vet center as a result of the speech I had made to the Kiwanis Club of which he is a member. His statement, which was quoted in the Journal, a local paper, was a very simple but profound one. He said, "I left Vietnam in 1967, but I didn't come home until 1982."

Now, given the fact that in our area of responsibility we have seen barely 1 percent of the Vietnam-era veteran population, we need the chance to continue bringing our veterans home in the coming years. It was drawn even closer to me as yesterday afternoon, late in the evening, I had a chance to go down to the Memorial. As I was standing there, I noticed a man over to my left who had on the rank of captain on his rain jacket, and he also had the Green Beret of the Special Forces. It was obvious to me that he was no longer in the military but he had brought these identifiers with him.

I walked over to him and started talking with him. He was tearful and crying about what he was experiencing at that moment. I found out he was from Norman, Okla., and he came here for one reason: to go to that Memorial and find a name. As I asked him how he was doing and what was going on, he said "You know, I still haven't decided what it was all about. I'm still hurting because of that, too."

Well, hopefully, after I talked to him, he is going to get in touch with a vet center out in Oklahoma, so that maybe we can help him find some of those answers.

I thank you, and I will entertain any questions that anyone has.

[The prepared statement of Mr. Burnette appears at p. 107:]

Mr. EDGAR. Thank you, Mr. Burnette. Your statement was very articulate and moving in terms of the personal experience that you have had.

I wonder if you might be patient with us and wait at the witness table as I call up Dr. Michael Miller, Assistant Regional Coordinator, for his statement, and then together we will ask both of you questions.

Mr. BURNETTE. OK. Thank you.

Mr. EDGAR. Dr. Miller, I appreciate your coming this morning. The full text of your statement will be made a part of the record at this point, without objection.[1] I might also say, Mr. Burnette, your extra materials that you have added to your statement will also be made a part of the record.[2]

Dr. Miller, you can proceed as you see fit. We would appreciate it if you could summarize to some degree.

STATEMENT OF MICHAEL R. MILLER, M.D., PSYCHIATRIST/TEAM LEADER, ASSISTANT REGION VI COORDINATOR FOR COUNSELING

Dr. MILLER. Thank you very much, Mr. Chairman, members of the committee.

In the text of my prepared testimony I listed the accomplishments of the Portland Vet Center over the last 3 years. One of those years I was the team leader. For two of them the psychologist, Dr. Tony Trawick, was the team leader. Today I would like to amplify some of the discussion about the diagnosis and the types of clients that come into that center.

Post-traumatic stress disorder is a generic condition. It is not unique only to Vietnam veterans. I think it is important for us to realize that as we focus on Vietnam veterans, rape victims, car accident victims, especially when there is loss of life or limb, the Hiroshima situation that was studied by Dr. Shattan and others, and the Buffalo Creek disaster in 1972 in West Virginia, are clear examples of where individuals not only in war are traumatized by events. These are not always persons who are especially vulnerable. At some point, at some level of stress, everyone is going to be affected, and often the effect is long-lasting. It is that type of counseling and that type of individual which we are dealing with in the vet center and through our community-based operations which is unique to the VA. We are able to make liaisons with crisis intervention teams, with mental health clinics, and we are invited to discuss post-traumatic stress both among the combat veterans of Vietnam and among the generic persons within the community who have also experienced those other traumatic events that I have just listed.

In addition, we have often described our post-traumatic stress disorder clients as being extremely dysfunctional. I would refer you to an American Psychiatric Journal article in January of 1982, which is not included in the text right now, but is titled "A Discriminate Analysis of Post-Traumatic Stress Disorder Among a Group of Vietnam Veterans." This was an OCS class, well educated, older than the average that went to Vietnam, but on self-report of 88 officer candidate school persons who went to Vietnam and experienced combat, 23 percent indicated on the self-report that they were suffering severe PTSD symptoms. Twenty-two percent self-reported moderate symptoms. And of the 88 that were studied, 20 percent had their wives also give reports that confirmed the self-reporting symptoms that these people were describing. All of these people were employed at that time, so not all clients that come into our Centers need the types of hospital treatments that Dr. Arnold and Dr. Kolb have suggested. Although those treatments are very important and we need more programs, the outpatient treatment for people who are still functioning in their jobs and in the community are extremely important.

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[1] See p. 114.

[2] See p. 116.

It is important to understand that the outreach teams are not doing low level counseling. This truly is psychotherapy. In my training at the University of Oregon in psychiatric residency, I had group experiences. But throughout my training, even as a Vietnam combat vet myself, I did not have any seminars in post-traumatic stress disorder. Truly, DSM-3 was not yet published, but we were quite aware of all the diagnostic classifications and were working closely with the St. Louis team at that time.

It is necessary to understand that in the group process, aberration, as described by Dr. Kolb, and utilizing amytal in his techniques, we can engender that same type of aberration in an outpatient population through group experiences. There is group sharing and many of the veterans develop large networks of persons—that is, in those groups they develop friends. One of the chief symptoms of post-traumatic stress disorder among Vietnam vets is isolation. Other victims of other traumas also show those same kinds of isolation—that is, rape victims often never talk to other men or stay away from other people. They need networks of people. People need to have large social groups in order to survive.

I would also like to discuss the difficulties that the vet centers are having with only 136 centers across the country for 2.7 million Vietnam veterans. There are many rural areas in which Vietnam veterans have a predilection to live in, which we can very poorly outreach under the present situation.

I would agree with Mr. Burnette from the Knoxville, Tenn., Center, that our outreach is similarly disappointing in those outlying areas. I have described in my text that our catchment area involves almost 30,000 square miles, two mountain ranges, and many isolated valleys in which Vietnam veterans again have a strong predilection to live in.

I would also like to emphasize that this outreach program, as I have found from traveling around region 6, is not truly unique. I talk to many social service workers who worked during the late 1940's and early 1950's that described large travel allowances to go out and get World War II and then later Korean war veterans who did not know about their benefits and were having particular difficulties. They found those programs extremely encouraging and successful at that time, and I think it is important to realize that our travel and our outreach is being sharply curtailed at the present time and it is important for us to get out and get these veterans.

I think it is important also to indicate the consequences of the program either discontinuing or if it were to move in under the Veterans' Administration Medical Centers at the present time, with their present capabilities of dealing with Vietnam veterans.

First of all, the mental health clinics in Portland and in Boise where I have surveyed are extremely full at the present time. They are working between 40 and 48 percent over capacity. Second, the number of clients that come to the VAMC's has dramatically increased because of the outreach programs. These are clients that are Vietnam combat veterans or Vietnam-era veterans who previously did not go to VA's. They had their individual reasons, but overall they showed a strong alienation from institutions like the Veterans' Administration. The outreach program has been very strongly positive in its help of getting Vietnam veterans into the VA Medical Center itself, when it is necessary. But the community based operation, as I previously described, has strongly helped the image of the VA in Portland and has strongly helped the community organizations in dealing with the subject of post-traumatic stress.

I think it is also important to realize that the client eligibility of the Vietnam veteran would be sharply curtailed if the program were to be discontinued. At the present time the VA in Portland is serving principally service-connected disabled veterans and that often runs in the range of 50 percent or greater only on a priority list. The low number of stress-related compensation claims that are adjudged positive have left Vietnam veterans suffering from post-traumatic stress disorder without the capability of being eligible for services if this program were to be discontinued.

In closing, I would like to say again the power of the community based operation to reach the individuals in the community when they do not make themselves available of the VAMC's or other hospital programs is extremely important, and in that regard the Vietnam veteran outreach program has been a tremendous success.

Thank you.

Mr. EDGAR. Thank you very much for your testimony.

I would like to ask a question of both of you. From your experience at the vet center and being team leaders, one presently and one in the past, is the demand for services on the rise or has it slackened off for the vet center operations?

Mr. BURNETTE. Most definitely on the rise, because what happens is you get a chain of events going, a catalyst going. You make a presentation and somebody says "Ah ha, that sounds like my brother." Then other veterans bring their brothers and sisters in.

One of the things we do, of course, is announce we're around. I will tell you how sometimes the numbers increase for me. I have a bumper sticker on my car that says "I'm a Vietnam Veteran." I have been flagged down, pulled over on the side of the road, about 10 times by other Vietnam veterans saying "Where did you get that? I want one of those." I have a supply and I hand it to them and they end up at the vet center.

Our numbers increase because of our publicity and we think they will continue to increase, especially as we get to go out in the hills and the valleys more and seek out these isolated areas.

Dr. MILLER. I would like to make just a short comment on that.

Our numbers of new clients is actually staying pretty close to the same. I think in my prepared testimony it shows a slight decline over time. That is a 3-year program. What is significant about that is the working caseload of the vet center has increased dramatically. As I pointed out in my testimony, our limitation right now is that all our client caseloads are full. We have also maximally utilized volunteers and others.

We at any time, after any public service announcement, any presentation, have dramatically increased the numbers with those outreach efforts.

Mr. EDGAR. Have you seen any change in the types of problems or different types of veterans coming to the centers over this time period?

Dr. MILLER. The client caseload itself has become more of a multiple problem caseload, but that is not unusual in any mental health setting in which these persons with multiple client problems take a longer time. The actual clients who come in have not changed from the first time when I went to the vet center 3 years ago. Fifty percent, as I described in my earlier testimony, often say to me "This is the first time I have ever gone out to seek help for my Vietnam experiences," and 25 percent indicate that this is the first time they had ever heard about the vet center operation.

Mr. EDGAR. Dr. Miller, critics of the post-traumatic stress disorder diagnosis state that many of these veterans were predisposed to the condition prior to military service and that the VA should not generally be liable for providing treatment or compensation for these individuals.

From your professional point of view, would you consider this statement to be true or false?

Dr. MILLER. In a general way, I would think it would be false. As I described earlier, post-traumatic stress disorder is a generic condition; that is, it exists across boundaries, not only in trauma from war. War, by itself, only happens to lead us to innumerable situations that are significantly traumatic. I think it is important to understand that we often neglect to understand that.

I do know that in one compensation claim in which I was involved I found that the initial psychiatric interview was determined not to be related to the war, based on the fact that the person's trauma was not extraordinary. Now, this trauma was that a person was in the rear but had shot a civilian at night by accident.

Now, I also had the very same clinician give a post-traumatic stress disorder diagnosis in a social security claim positive to a woman who had been raped and was suffering the same identical symptoms. What I felt in that situation is endemic, the fact that war is assumed to be traumatic in general and people are supposed to put up with it. Therefore, we tend to neglect the amount of trauma that combat situations can affect people.

Mr. EDGAR. Thank you.

I must go over to the House floor for a few moments to make sure the jobs bill gets put through. I have a little concern on that legislation. I would like to turn the hearing over for a few minutes to a new chairman, Mr. Evans.

I yield to Mr. Smith of New Jersey.

Mr. CHRISTOPHER H. SMITH. I thank the Chairman for yielding.

I have a couple of questions. First of all, I want to commend you both for your very fine statement. I think it will provide the subcommittee with very good insights. I do have a couple of questions.

First of all, Dr. Miller, in your prepared testimony on page 17 you speak of contract fees being a mixed blessing. I would just ask that you elaborate on that. You do, in your written testimony, give some of the particulars, but orally I think it would be very helpful for the members who are here.

Dr. MILLER. OK. The contract fees program was initiated in the legislation nearly the same time as the outreach program, but no administrative moneys were established to put that program into effect. In May of 1982—and I want to correct the dates on there. The 1983, July and May, are not right. I think those may have been corrected in your copies.

The contract fees program funds private practitioners, clinicians, counselors, psychologists, et cetera, in the outlying areas, trying to reach veterans who are not able to get to vet centers. The difficulty with the contract fees program is, one, there is not a large number of trained clinicians in the field who have had any experience with Vietnam veterans in particular, or post-traumatic stress disorder in general.

Second, based on the cost effectiveness of the vet centers themselves, the costs to the program, of running the contract fees program, is about twice per client what the vet centers are costing.

Those are the negative aspects.

On the positive aspects, it is one means of reaching Vietnam veterans in the outlying areas when we are so short staffed at present.

Mr. CHRISTOPHER H. SMITH. Is that a problem that is nationwide or just germane to your area?

Dr. MILLER. I can speak only firsthand about my area. My understanding from talking to team leaders throughout region 6 is that it is general throughout our region. I have had some discussions with people across the Nation, and maybe Mr. Burnette could describe his area.

Mr. BURNETTE. Within my area of vet center operations, I have had that problem. One of the things that I find with the private practitioners—and this has been talked about by other witnesses before me, in particular Dr. Arnold talking about staff and things like that—is the fact that their training has been such that looking at a veteran and being able to make this kind of diagnosis seems to be a real problem for many of them.

Presently, in my combat rap group, I have two Vietnam in-country combat vets, just like myself, who also work in a mental health facility about 50 miles from us. They wanted to start up a rap group up there. Before they did that, I said please come down. Basically what they are doing is they are going through the rap group as participants to get in touch with their own Vietnam experiences and to understand basically what we have been talking about in teaching in our professional workshops. I think they are going to be much stronger and much better—I know they are—counselors and therapists when they go back and treat the Vietnam veteran.

They have said to me, "You know, I never realized that these groups could go like this. It's a good thing I did this already."

Mr. CHRISTOPHER H. SMITH. You would say, in a sense, that the counselors themselves, or the psychiatrists, really have to get in touch with what is really going on with the Vietnam vet; then they can apply their discipline to providing some treatment.

Dr. MILLER. That's absolutely correct, sir.

Mr. CHRISTOPHER H. SMITH. I have two questions for Craig Burnette.

First of all, you spoke very well on networking and how that has worked in your own vet center. I know we have vet centers in my own State, three of them, and one in my district in the city of Trenton. They have had some networking, but I don't think it has been as elaborate as your own. Again, I think your experience should be duplicated and this committee and the members who have vet centers in their area or in their State should take back what you have shared in terms of really getting the message out.

You spoke of, despite all your best efforts, still only reaching some 1 percent of the Vietnam-era population. Obviously the remaining 99 percent are not all in need of Vietnam vet centers counseling or programs. However, could you give me your best estimate as to the remaining percent of clientele that has not been reached?

Mr. BURNETTE. I am responsible for a 14-county area in east Tennessee that stretches as long as—I think the furthest point away from my vet center is 192 miles to where I would have responsibility for that area. Of course, I have been in operation only 14 months, as opposed to his center of 3 years. In that area they have estimated that we have 70,000 Vietnam-era veterans. Again, not all need our services.

From the statistics alone that I have seen through the research and the studies—and there is research done by a vet center team leader in Huntington, W. Va., and now he is chief of psychology at the Mountain Home VA. His name is Giles. He believes that the incidence of PTSD and the problems with it might be higher in rural vets than what we are seeing. He has his reasons behind that.

So I am inclined to believe that, of the 70,000 or so we are still talking about—I would like to see them all, but at least 50 percent of them are going to need my services, I believe.

Mr. CHRISTOPHER H. SMITH. Thank you very much for your testimony.

Mr. EVANS [presiding]. Mr. Burnette, I have some questions. I sympathize with your having a 14-county area. That is about the size of my congressional district, and it is tough for me to get around with the staff I have to service my constituents. You seem to have a very similar problem. I understand from your testimony that your vet center in Knoxville is approximately 150 miles away from the nearest VA medical facility. I have a similar problem in my district. If they close the Peoria Center, it would take 2 to 2½ hours for a veteran to travel to Iowa City, Iowa.

What kind of impact would proximity have on a veteran with post-traumatic stress disorder in seeking treatment?

Mr. BURNETTE. Sir, I believe that if we were to close shop, the impact would be devastating to our veterans. First of all, they won't go, the overwhelming majority of them won't go down there, for various reasons, or to any of the VA facilities; second, right now, they have been talking 5 years or so—5 years to really educate our community and get our professionals in the area educated and working hard. So I don't think they have anything to fall back on right now. We're it. And if we go, they're in trouble as far as I'm concerned.

Mr. EVANS. If you will excuse an old Marine expression, you have a very "gung ho" staff. How is the morale of your team affected when you have to periodically appear before congressional committees to ask for a 1-, 2- or 3-year extension of your program? Wouldn't it be much better to extend this program for a period longer than 1 or 2 years?

Mr. BURNETTE. Yes, sir.

Mr. EVANS. How do you attract and retain good people when you periodically have to seek extensions and also face these problems of funding. What effect does it have on the credibility of your program in the veterans community when you have these problems?

Mr. BURNETTE. To the staff, maintaining the morale, I would like to speak generically about that, in that I get to meet other staffs of other vet centers.

Besides the professional credentials—and, of course, we look at that—every one on my staff and the people I know are personally committed because of our experiences, because we know what people have gone through. We have gone through it, also, and we understand what's going on. So with that personal commitment, I will probably get a lot more work hours out of my staff than the law allows. However, because of our client population, et cetera, it is draining. We have to watch each other very closely for burnout, or when the morale gets very low. We say "not one more." You know, "I just can't take another day," or whatever. We do that. We try to watch that very closely.

But in terms of me coming up and talking about a 1-year extension or 2-year extension—of course, we know what we are doing is right. We know that. Please, someone out there, recognize it and give us a chance just to go on unencumbered. Evaluate us, that's OK. You're always welcome in my vet center. We're ready for that because we know what we're doing is right. So give us the chance to do it. That's basically the kind of feelings I get from them.

Our veteran population, when they found out—the guys and gals in my rap group—when they found out I was coming up here, the first thing they said, "Who do we write? Who do we write? They're going to do away with this program? No way."

So they were somehow dispirited. They thought, "Hey, this could really happen. You mean you people could really cease to exist?" I said, yes, with the legislation as is—of course, that was disheartening to many of them.

Mr. EVANS. I am sure both of you run into veterans of other eras, and perhaps Gold Star mothers, Red Cross volunteers and civilians who had experiences in Vietnam. I take it they are technically ineligible for your treatment.

What, if any, referrals do you make for these folks? What can you do for them?

Dr. **Miller**. Yes, in my center I have seen a number of World War II veterans, three Korean veterans, in specific, one Gold Star mother, and one wife of a combat Navy pilot.

The referrals we can make are usually to mental health clinics or to the VA, if they still have eligibility under insurance. Basically, we tend to take care of those people as best we can at the center because there are very few facilities, given the amount of social dollars in mental health right now.

Mr. **Burnette**. The same thing. We don't turn a veteran away, of course, when they come in the door. We sit down and talk about it, who we service, et cetera. But we refer out to other agencies or whatever.

However, I would like to share one thing. I presently have a client who is a World War II, Korean war, and Vietnam veteran. He has been out of the service for 7 years now. He has had numerous problems and has been diagnosed several different ways. What we are doing with him is bringing him through his wars. We are now to the Korean war. He brought in his memorabilia from Korea 2 weeks ago and shared that with us and with me, and all the experiences he had there. Obviously, there are veterans out there who could use the kinds of services that we are doing, whether they are Vietnam era or not.

Whenever we have someone that doesn't fit in that era, though, we go ahead and refer out to other agencies or their local outpatient clinics.

Mr. **Evans**. Thank you.

Mr. Penny.

Mr. **Penny**. No questions.

Mr. **Evans**. Mr. Daschle.

Mr. **Daschle**. Thank you, Mr. Chairman.

You both have done the committee a real service and I think you have represented the Outreach centers and the whole concept about as well as anybody that has come before the committee since I have been here. I am very grateful to you for that.

I was just thinking as we were talking about this, the bill would delay, at least for 1 year, at least the bill that Chairman Edgar has authored, would delay the incorporation of the vet centers into the VA for at least 1 year.

After reading this report this morning about the task force, it could be that you could become a member of the Department of Agriculture. But I don't know what plans the task force has for eliminating the Veterans' Administration. In any case, I think the case that you have made for autonomy is extremely important.

As I go through the vet centers that I have, that is the secret, it is that autonomy, it is that flexibility, it is the opportunity really to show that you aren't some part of a huge bureaucracy.

That really leads me to my question. Our slogan is "help without hassles." How much hassle are we now getting from the bureaucracy when it comes to post-traumatic stress, when it comes to the point where we have to go beyond the sessions that we can provide in the Outreach centers? Let's assume, then, we need some therapeutic care. What kind of hassles are we getting from the VA hospitals?

Dr. **Miller**. Our cooperation with the VA is based mainly on personal contacts. In Portland, in my inpatient unit, I have a Vietnam veteran as the director, so I am getting very few hassles with admitting patients to that inpatient unit. I am having difficulty within that program, though, establishing a specific ward or a specific unit or a specific program in the Portland area for Vietnam veterans. It is a general psychiatric ward.

Mr. **Daschle**. In your interface with the VA hospitals, what kind of appreciation of post-traumatic stress is now present within the hospital system itself?

Dr. **Miller**. It is highly mixed.

Mr. **Daschle**. It's mixed?

Dr. **Miller**. Very mixed.

Mr. **Daschle**. To what do you attribute that, that mixed feeling? Is it experiences? Is it philosophy, or is it a lack of appreciation? Is it a lack of policy implementation on the part of the VA? Is it a factor of all of these?

Dr. **Miller**. I think all of those. First of all, the question Mr. Evans asked earlier about what our credibility was, based on the fact that we are funded on a temporary basis, almost all our employees are schedule A, which means a temporary employment that won't last more than 5 years, and the program funded for no more than 3 years. I often find that within the fiscal service, supply service and others, well meaning people who will tell me there really isn't any point in doing that, you're not going to be around long enough to see the results.

Within the clinical staff I do find a strong denial, again of what I pointed out earlier, of the fact that war, itself, is a traumatic stress. They see all the symptomatology of the client. Where they would admit that stress happening from a car accident was clear cut, or a rape, they will not allow a war experience to be counted unless it is overwhelmingly traumatic, much as you pointed out in your earlier testimony. So from the credibility point of view and from the professional denial point of view, we find strong opposition to post-traumatic stress disorder.

On the compensation area, it is even stronger in the sense of making it difficult to get a service connection.

Mr. **Daschle**. Mr. Burnette, do you have anything to add to that?

Mr. **Burnette**. Only that I agree, that those are the kinds of things I have seen and have been faced with. I do believe that as a result of our vet center activities, our special efforts to seek out staff members in the hospitals individually, and sit down and talk with them and put on programs like I am going to put on in May at their hospital with a nationally recognized expert coming in, by seeking out those people—And do you know what I look for? I look for Vietnam-era veterans, too, within the VA system, to talk to them.

I find as I seek those people out and make those personal contacts, that is the way I start getting through and getting things done.

Dr. **Miller**. If I might add one comment to that, one of the difficulties is that the professional community has not had Vietnam-era veterans within it, and it is simply a matter of years. I now have at my center three psychology interns within the University of

Oregon psychology program, using our center as their group experience. So we have some credibility from the academic aspects.

But at the time I graduated from my psychiatric residency in 1979, I was the only veteran that I knew of in the country who had completed a psychiatric residency and had been an enlisted man prior to college. That is unique only in the sense that that's the number of years it takes to go to college, medical school, and through a residency to graduate. So now we are seeing more and more Vietnam-era veterans coming out from the professional community. So, over time, that may change.

Mr. **Burnette**. My parent facility, the Nashville VAMC, had some people very sensitive to this issue, before I started to exist, in the mental health and behavioral sciences section there. Dr. Oakley Ray is the chief. In fact, he had already started outpatient groups for Vietnam era veterans, so he had gotten some things rolling down there. Thus, when our vet center opened, I had some widespread acceptance and it really helped having a person who was chief, understanding these issues and ideas. It helped me in my work with my parent facility.

Mr. **Daschle**. Mr. Chairman, I am out of time. I could pursue questioning here for some time. Let me just summarize and close by a comment that I feel is important to make.

The general public, for some reason, holds many Federal employees in low esteem. I just wish we could get the message of the kind of dedication and the kind of commitment and the kind of involvement that these people have on a day-to-day basis out to the American people. I think it would change the perception within moments if they could see that quality that you represent.

So I just wish you well. There are a lot of us watching very closely and wishing you the very best as you go forth in your work. In my opinion, for those who are affected by this in a favorable way, there is nothing more important that we can do than to give them that service. You do a tremendous job.

Thank you.

Mr. **Evans**. I would like to concur in Mr. Daschle's comments. One thing I would like to ask you about before you leave is in regards to the effect on society. I think programs like yours are good for the individual veteran; things like the Vietnam Memorial and the parade we had in November are positive things. We enrich the political process, and help society as well when we have programs such as yours.

Do you feel these programs have a greater impact than simply on the individual?

Mr. **Burnette**. Yes, sir. I believe so, because of the response I get back, in dealing with all different kinds of groups at different levels. As I mentioned before, my last presentation was to a senior citizens group, a small town 30 miles from Knoxville to the Kiwanas, to all the people that I meet.

In fact, in my statement I take a very proud stance as a Vietnam veteran and I state to people "You may question the war and make moral judgments on it; however, don't make moral judgments on the warrior. Let's see where they're coming from."

That is what I say to them, and I believe if you went to some of our presentations and workshops, or go back through the records and talk to some of the people I presented to, I think you will see that we are perceived as a positive force, a force that is moving within society.

I personally believe that Vietnam-era veterans are going to turn out to be, as we age, the strongest group of people this Nation has ever seen in terms of commitment, because how can you go through the experiences that we have gone through and not come out strong in the long run if you have the right kinds of help and assistance. That's what I hope we are providing.

Mr. EVANS. We thank you both for your commitment and service to this country and your fine testimony here today. Thank you very much.

Mr. EVANS. At this time we'll hear Dr. Earl Brown. Would you come forward, please. For the record, Dr. Brown is the Associate Deputy Chief Medical Director of the Veterans' Administration's Department of Medicine and Surgery.

Dr. Brown, I would ask you to introduce your associates for the record.

STATEMENT OF D. EARL BROWN, JR., M.D., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY AUDLEY HENDRICKS, ASSISTANT GENERAL COUNSEL; ARTHUR S. BLANK, M.D., DIRECTOR, READJUSTMENT COUNSELING SERVICE; ARTHUR J. LEWIS, M.D., DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR FOR PROFESSIONAL SERVICES

Dr. BROWN. Very fine. Thank you, Mr. Chairman.

On my left is Mr. Audley Hendricks, who is the Assistant General Counsel of the Veterans' Administration. On my immediate right is Dr. Arthur Blank, who is the Director of the Readjustment Counseling Service. On his right is Dr. Arthur Lewis, who is the Deputy ACMD for Professional Services.

Mr. EVANS. If you would like to proceed with your testimony then.

Dr. BROWN. Mr. Chairman, with your permission I would like to comment on one question that was raised prior to our testimony, and that has to do with the distinguished physician program. I think modesty caused Dr. Kolb to perhaps not pay adequate due to that particular program. It is, indeed, a program of distinguished medical people who have, indeed, made a name for themselves in a specific area of expertise. This program, at least in my experience with the VA, has not always been filled. The criteria is very tough to be selected for it, and they are, indeed, a distinguished group.

Mr. EVANS. Thank you for pointing that out.

Dr. BROWN. We are pleased to appear before you today to present our views on H.R. 1443, a bill "to amend title 38, United States Code, to extend by 1 year the period during which Vietnam-era veterans may request psychological readjustment counseling from the Veterans' Administration and to direct the Administrator of Veterans' Affairs to carry out a comprehensive study of the prevalence of posttraumatic stress disorder and related readjustment problems among Vietnam-era veterans."

We support the purposes of H.R. 1443 and certainly expect to work closely with this committee in this important area. It should be noted that those Vietnam-era veterans who have requested readjustment counseling services before September 30, 1984, and continue to need those services after that date, remain eligible under the law. The mechanisms by which those services will be provided after that date have not yet been established.

We have formed an agency task force to address the many issues raised by that statutory mandate. However, we have experienced a continuing increase in the counseling workload which suggests there remains a measure of unmet need.

The Veterans' Administration is strongly committed to the readjustment counseling program. Parenthetically, I would like to say, contrary to the suggestion of Congressman Richardson, we are indeed, I repeat, strongly committed to the readjustment counseling program. Our efforts to plan for the future of this program are still at a relatively early stage. Available data and planning needs are such, however, that we would not oppose the proposed delay in the transition date, subject to the task force's ultimate findings and the recommendations of the Chief Medical Director.

Section 2 of the bill would require that the VA conduct a truly comprehensive survey and provide Congress a detailed report on its findings and conclusions by December 31, 1984. The bill calls for a survey both of Vietnam-era veterans readjustment and their general health status.

The Lou Harris and Associates study of public perceptions of Vietnam veterans in October 1979, produced considerable information on the socioeconomic status of Vietnam veterans. A more comprehensive study published in March 1981, by the Centers for Policy Research covered Vietnam veterans' income levels, employment achievements and job status, incidence of alcohol and drug abuse, number of arrests and many other elements related to the psychosocial adjustment of Vietnam-era veterans.

Both from these studies and from our experience in the readjustment counseling program we in the VA already have a significant body of information about Vietnam-era veterans. While there is merit to expanding our understanding of the status of the veterans' readjustment, it is unlikely that the study required by H.R. 1443 could be designed, conducted, and a report completed in the time required by the bill. For purposes of our planning, such timeliness would be essential.

Mr. Chairman, I turn now to update the committee on the status of the readjustment counseling program and other matters in which you have expressed an interest.

All vet centers are now fully operational. The last two opened during January 1983, bringing the total to 136. As of March 1983, the 136 vet centers have been operating for an average of 2 years and 4 months. The 28 Centers which were opened during calendar year 1982 have been open an average of 11½ months.

The other major arm of the program, the fee-for-service contract, is also now operational and working smoothly overall. Approximately 6,000 veterans and family members have been referred to nearly 400 private service providers who have been awarded contract provider status. Contracts are still being awarded. However, the veterans and families are still learning about the program. We expect that $7 to $8 million will be utilized in the contracts program this fiscal year and the full earmarked $11.2 million should be used during fiscal year 1984.

Keeping in mind that the cost per visit to contract providers is somewhat higher than for vet centers, it can be said that the contracts program is providing a modest, useful, but somewhat costly supplement to the vet center modality.

Progress has been made concerning the vet center program. Staff development in the field and in Central Office and strengthening of management controls have progressed considerably during the past 18 months. We have increased the number of program operating officials in VA Central Office from three to five, and the number of supervising officials in each region from one to three. The professional status of vet center staffs is slowly increasing as a matter of policy. At present, 51 percent of the service providers at the vet center level have mental health or human services degrees of some type, and 25 percent are mental health professionals.

Inpatient programs for posttraumatic stress disorder have been developed at 8 medical centers with a total of 238 beds dedicated to treating this disorder. And as you have been told, other facilities provide special groups and activities for Vietnam veterans without designating these activities as special programs. 1,296 Vietnam veterans received hospital care for posttraumatic stress disorder last year. Both the inpatient program and the outpatient activities have been very busy. Requests for these services have grown steadily.

Our counseling experience to date has shown that veterans coming to our vet centers are experiencing more severe problems than we originally anticipated. As a manifestation of that unexpected severity of problems, we are finding at present that approximately 50 percent of these veterans require counseling over a period longer than 60 days. About 12 percent are being referred for psychiatric hospitalization, and about 14 percent are being referred for treatment at a VA mental hygiene clinic. We estimate that 26 percent of the clients come for counseling with moderate to severe employment difficulties, and that approximately 76 percent of those have been helped to secure steady employment. In this connection, also, 120 Department of Labor disabled veteran outreach counselors are now working part-time in VA vet centers.

Staffing for improving management of the program has largely ended prior conflicts and misconceptions in the field over lines of authority and program administration issues. The first readjustment counseling program guide has been published and disseminated to the field, and it has been followed by the issuance of two detailed policy directives. A systematic psychological assessment format for veterans coming for help with psychological problems has been prepared and is now being introduced.

Initial operating difficulties with the fees/contracts programs have been resolved and a revised request for funds proposal protocol has been issued. Program-wide collaboration with regional medical education centers has been instituted for all major training activities, and systematic program-wide supervision and training in management is also provided by Central Office staff.

Mr. Chairman, this concludes my statement. I and my staff will be very pleased to answer any questions.

[The prepared statement of Dr. Brown appears at p. 138:]

Mr. EVANS. Mr. Brown, on page 5 of your statement you indicate that the contractual program is proving to be modest, useful, but expensive. If the contract authority was not extended, or extended on a limited basis, would it be necessary to strengthen the vet center program to provide for those services?

Dr. BROWN. I see the contract program as an excellent supplement to what we're providing in the vet centers, and without those I think we would have to make some sort of an adjustment in order to take care of the need. We do need an accurate assessment of that need in order to plan for the future. Indeed, if the contract program were eliminated, I think we would have to expand.

Mr. EVANS. Your statement indicates that there are 136 vet centers that have been operating for an average of 2 years and 4 months. Can you tell us how many vet centers have been in operation less than 18 months, less than 12 months, and less than 9 months?

Dr. BROWN. I will ask Dr. Arthur Blank to address that.

Dr. BLANK. Thirty have opened since the beginning of January 1982. The average length of time open for that group of 30 is 10 months. That is as of this month. The most recent two to open opened in January of this year.

Mr. EVANS. Dr. Blank, the American Legion states in its testimony that their field representatives, in surveying VA medical facilities, have discovered that "some VA physicians discount any mention of Vietnam service or combat during a psychiatric evaluation and others do not elicit any military background at all during a posttraumatic stress disorder examination."

I would like to ask you if this is so, and does the VA have any policy requesting admitting physicians or evaluating psychiatrists or psychologists to provide a general review of military service records related to a veteran's medical or psychological condition?

Dr. BLANK. I think there are standing professional policies at all facilities in that regard. The problem is in implementation—and this has been alluded to by Dr. Kolb and others. I think frankly it is a problem that is endemic in the mental health field, not limited to VA mental health professionals.

It is difficult for mental health professionals, especially those who have never seen military duty, and even more so have not been involved in a war themselves, it is difficult for them to go about obtaining a military history and to know when they have obtained one which is accurate and sufficient to understand an individual's psychology.

Mr. EVANS. Dr. Brown, on page 6 of your statement you indicate that veterans going to vet centers are experiencing more severe problems than originally anticipated, and about 14 percent are being referred for treatment to VA mental hygiene clinics.

Now, it is my understanding that the VA mental hygiene clinics are operating at about 50 percent above their capacity. Can you explain to us how this would affect the quality of care which these 14 percent of Vietnam veterans are receiving through the mental hygiene clinics?

Dr. BROWN. I am not aware of that 50 percent over capacity. I am confident that we are taking good care of the Vietnam veterans. I think the rapport that has been established between the vet centers and VA medical centers is such that, indeed, in many areas, they are giving preferential treatment to Vietnam veterans to insure that their needs are satisfied. I think I heard some testimony earlier to that effect.

Mr. EVANS. Dr. Blank, we have heard that it takes an inordinate amount of time to get veterans admitted to a VA alcohol and drug dependence program, as well as getting veterans admitted for inpatient psychiatric care. Could you comment on this?

Dr. BLANK. My comment is a general one. I think this is an area where the need for services does strain the resources available.

Mr. EVANS. Thank you.

Dr. BROWN. I would second that. Dr. Ewalt, who is behind me, is the Director of the Mental Health and Behavioral Science for the Veterans' Administration. He has told me that many of our alcohol and drug clinics are overloaded.

Mr. EVANS. Thank you.

Mr. Smith of New Jersey.

Mr. CHRISTOPHER H. SMITH. Thank you, Mr. Chairman.

First of all, thank you, Dr. Brown, for your statement. I would like to commend Dr. Blank for his work on behalf of this committee in improving the management of the delivery of services under the readjustment counseling program. I think you have brought the program along a long way. I think this committee and every Member of the House should know that you have done an outstanding job in that endeavor.

Dr. Brown, I do have a few questions to ask of you. The first is that Dr. Miller, the witness who preceded you, indicated that contract counseling was a mixed blessing, the downside being, it is my understanding, a lack of hands-on experience on the part of those practitioners who have not had the Vietnam experience, as well as a lack of working knowledge with the posttraumatic stress disorder.

How would you assess the relative quality of the vet center counseling as opposed to the contract counseling?

Dr. BROWN. First of all, the vet center counseling I think has a proven record. They are doing an excellent job, and I concur in your commendation of Dr. Blank. I think he has done an excellent job.

As far as the contracts are concerned, we recognized last fall that there was inadequate specificity in the protocol for the RFP and therefore rewrote it in order to tighten it and to give extra credit to those applicants with such experience as you're referring to, such as experience with Vietnam veterans. I think that will assist the contract program tremendously.

As of today, or as of the end of January, at least, we only had 1 month's experience with the new protocol. I think that Dr. Blank would agree with me, that it is looking up.

Mr. CHRISTOPHER H. SMITH. I would just ask that we be periodically assessed of how well that is going. That is another good improvement.

Dr. Brown, what is the cost of a typical counseling contract and how much is paid for individual visits and how much is paid for the group visits?

Dr. **Brown**. I will ask Dr. Blank to address that.

Dr. **Blank**. Our estimates at the moment are that the cost per visit in the contract program is somewhere between $40 and $45 for an individual visit, and that a group visit is probably costing somewhere between $25 and $30.

Mr. **Christopher** H. **Smith**. One last question.

How many visits does a typical veteran make to a vet center and what would you say the ratio is between a new veteran walking through the storefront door as opposed to a repeat visit?

Dr. **Blank**. I think the clearest way of breaking that down is as follows: about 50 percent of our clients are being seen for a relatively short period of time and a few number of visits, an average of about four visits during a space of less than 2 months. Another 50 percent of our clients are being seen over a timespan of greater than 2 months and for an average of about 24 visits.

Mr. **Christopher** H. **Smith**. So it is rare that somebody walks in once and that's the last you see of him?

Dr. **Blank**. I wouldn't describe it as rare. Statistically it is uncommon.

Mr. **Smith**. Thank you. I yield back the balance of my time.

Mr. **Evans**. Mr. Daschle.

Mr. **Daschle**. Thank you, Mr. Chairman.

I applaud your endorsement of the extension. I think it certainly comes as good news to many of us that see the job being done at the Outreach centers and the need for that kind of effort to continue.

I would like to go back to an earlier line of questioning and ask you—obviously, one of the biggest concerns of these Outreach centers is post-traumatic stress. I have a circular dated May 3, 1982, regarding post-traumatic stress, Dr. Brown, signed by Dorothy Starbuck.

Is that still an operative circular?

Dr. **Brown**. I can't answer that, Mr. Daschle. That is a Department of Veterans Benefits circular and not a DM&S circular.

In commenting on your previous question in that regard, if you need clarification—I don't have someone with me today from DVB, but if you need further clarification on that specific issue, we would be glad to provide it.

As far as obtaining medical care by the Department of Medicine and Surgery, that circular does not apply.

Mr. **Daschle**. Obtaining medical care?

Dr. **Brown**. Yes.

Mr. **Daschle**. Well, we're not talking about medical care——

Dr. **Brown**. I'm talking vet center care or——

Mr. **Daschle**. Let me just relate a little bit—and, Mr. Chairman, I ask unanimous consent that we insert this circular in the record.

Mr. **Evans**. So ordered. It will be included in the record.

[The circular appears on p. 145:]

Mr. **Daschle**. I am really concerned about it and I hope that we can get some clarification for the record on this. Let me just read a couple of things.

This says, "To summarize the basic requirements that must be met to establish service for PTSD, a history of a stress as related by the veteran is, in itself, insufficient." Now, that's an incredible statement.

"Service records must"—and it is underlined here in the memo—"must show the veteran was wounded as a result of enemy action and/or was in combat against the enemy, was a POW." How in Heaven's name can most of these guys come in and say "I think I am suffering from some kind of psychological illness and I don't have a thing to show that I was in combat or in enemy action or a POW. I don't have any medals. But I'm supposed to show you all this in order to get service." That's what this memo says.

I am not directing this criticism at you personally because I understand this isn't your area. There used to be a commedian that said "It's not my job."

Dorothy Starbuck wrote this, and one of my frustrations is that we never seem to be able to bring Dorothy among us often enough to address these things of her directly. I would sure like to have a good, long talk with Dorothy about a lot of things.

"Objective evidence of a life-threatening stress or in service" is another critiera that they have to demonstrate. "A diagnosis of PTSD to show adequate findings and clinical examination which describes the stress or symptoms or manifestations."

You know, we are talking to these veterans about help without hassle, and all of a sudden a memo like this comes out and I haven't seen anything to say this is no longer operable. So my feeling is, as much as we have promised, and as good intentions as Dr. Blank and several of the people we have had come before the committee this morning are, this just cuts right across any kind of an effort that we're trying to provide to insure that help without hassles is more than just a bumper sticker.

So I just hope we can get more than a clarification on this, Dr. Brown, that we can actually show that all this garbage, this bureaucratic rhetoric about obstacles and hassles really isn't the fact. I would sure like to get that as quickly as we can.

Dr. **Brown**. Mr. Daschle, we would be pleased to answer any questions you have on that.

Mr. **Daschle**. Well, that's my question.

Dr. **Brown**. I mean for the record we will supply it. I have never known Dorothy Starbuck to shrink from any forum. I am sure if she had known you were going to address this area she would have been pleased to have been here.

[Subsequently, the Veterans' Administration furnished the following information:]

The circular which is referred to is DVB Circular 21-82-7 (dated May 3, 1982), "Post-Traumatic Stress disorder ratings." A copy is attached.

The Board of Veterans Appeals has not issued a memorandum giving instruction about publicity factors and PTSD issues. The case which has been referenced as an example appears to be a BVA recent decision. In the decision the Board did not say that they believe his claim was valid because his description of the event predated wide publicity of post-traumatic stress disorder. The pertinent discussion centered around the fat that the veteran's description of the event was replete with authenticating details and that there was evidence of the circumstances of the veteran's service which provided a corroborative basis. While the phrase "at a time prior to wide publicity" is included in the decision, by taking it out of context gives it an emphasis that was not intended. The Chairman of the BVA has informed the Director of the Compensation and Pension Service that the Board has and will continue to make their judgments by the weight of the evidence in each individual case.

POST-TRAUMATIC STRESS DISORDER RATINGS

1. The purpose of this circular is to clarify the requirements for the establishment of service connection for PTSD (post-traumatic stress disorder) and to point out problem areas we have encountered in our review of claims. Five points will be covered.

a. Objective Evidence of a Stressor in Service.—

(1) A considerable number of claims reviewed showed lack of objective evidence of identifiable stressors. These claims contained only the veterans' own statements, given usually many years after service and without concrete evidence in the claims folders to substantiate the statements.

(2) Objective evidence of a stressor includes, but is not limited to, official service records indicating medals or commendations awarded for combat; wounds suffered as a result of enemy action or for acts of valor; duty assignment in a grave registration unit; medical or paramedical duties on a burn ward; or experience as a prisoner of war.

b. Acceptable Diagnosis of PTSD for Rating Purposes.—Many of the claims reviewed had an unacceptable diagnosis of PTSD. Generally, the diagnosis was unacceptable because the symptomatology described did not support such a diagnosis; an identifiable stressor was not shown or was not adequately described; or prior reports or history indentified a type of mental disorder which could not support a diagnosis of posttraumatic stress disorder.

c. Reconciliation of Conflicting Diagnoses or Conflicting Psychiatric Reports.—A large number of the claims reviewed showed a diagnosis of PTSD, but the file contained conflicting evidence (either in the service records or in medical reports or examinations) with no attempt to reconcile the evidence with the diagnosis. Some claims contained conflicting diagnoses (e.g., PTSD and anxiety neuroses, unstable personality disorder) with no request made to the VAMC to reconcile the discrepancies in the diagnoses.

d. Confusion About the Applicability of DSM-III, Program Guide PG 21-1, Section O-12, and Information Contained in Examination of PTSD.—

1. Several stations have inquired as to what constitutes a stressor and whether it is to be limited to an immediate life-threatening experience.

(2) Stressors include, but are not limited to, immediate life-threatening experiences. Examples of stressors which are not immediately life threatening include grave registration, nursing duties in a burn ward, and POW experiences. Both DSM-III and PG 21-1, section O-12, are applicable. Stressors include incidents of armed conflict or enemy action, natural disasters, and manmade disasters (both accidental and deliberate), which occurred while on active duty.

e. Lack of Continuity—In PTSD cases, continuity is not a requirement. PTSD, as the program guide and DSM-III point out, may be established as service connected, even though a considerable period of time may have lapsed between the stressor and its chronic manifestations.

2. To summarize, three basic requirements must be met to establish service connection for PTSD:

a. Objective evidence of a life-threatening stressor in service;

b. A diagnosis of PTSD acceptable for rating purposes; and

c. Adequate findings in the clinical examination describing stressor and symptoms or manifestations. PG 21-1, section O-21, and DSM-III provide standards and guidelines.

3. A history of a stressor as related by the veteran is, in itself, insufficient. Service records *must* show the veteran was wounded as a result of enemy action and/or was in combat against the enemy, was a POW, or must otherwise substantiate a stressor of sufficient gravity to evoke symptoms in almost everyone, as required by DSM-III.

4. If supportive evidence is not in file, the service department should be requested to furnish information as to duty assignments, units to which assigned, combat unit duty, Purple Heart as well as other combat, medals, decorations or commendations. The veteran may also be asked to furnish any evidence in his/her possession.

5. Rescission.—This circular is rescinded April 1, 1983.—Dorothy L. Starbuck, Chief Benefits Director.

Mr. DASCHLE. Mr. Chairman, maybe we can arrange to have another hearing and we will invite Dorothy to come up. Could that be arranged, Ralph?

Mr. CASTEEL. Yes, sir, that can be arranged.

Mr. DASCHLE. I would sure like to have it. If tomorrow isn't too soon, perhaps we can get started.

Let me ask you this—and this may not be something you can address, either. This goes back to that decision about posttraumatic stress that really concerns me a little bit. It is a memorandum from the Board of Veterans' Appeals, and in this case they did grant the assistance requested for posttraumatic stress. But the clause here that concerns me the most—and if you can address this as an official within the VA, I would appreciate it.

It says, "Primarily, we think that his claim is valid because the description of the event has predated wide publicity of posttraumatic stress disorder." That was the reason given, that it predated the wide publicity.

Well, what happens to the poor guy that may have become aware as a result of this publicity that he may have posttraumatic stress? Is that going to be a reason to prevent him—if he can't show he has got a medal or that he was in some kind of a conflict, is that going to prevent him from getting that kind of service?

Dr. BROWN. No, sir. Mr. Daschle, I know you are aware of this, but maybe the audience is not completely aware of it. But what you are referring to has to do entirely with compensation and not medical care.

Mr. DASCHLE. That's right. That's what I'm asking.

Dr. BROWN. This does not preclude someone coming in to any of our facilities and being taken care of.

Mr. DASCHLE. The point I am making, this veteran was awarded compensation. What happens to a veteran who comes in now, several years after this publicity has been generated, and says "I have posttraumatic stress?" Is there a bias, a prejudice against veterans who are now trying to demonstrate they have posttraumatic stress simply because of that publicity?

Dr. BROWN. I do not think so.

Mr. DASCHLE. Again, I would hope that Dorothy or somebody over there can address this issue. It is a very sensitive point. I mean, obviously you're going to get more attention to the issue; you're going to get more people who understand how serious this situation can be, as we learn more about it and as the information becomes more widespread. If that alone is used as a reason to deny compensation, then I think we're going to have to change the law in some regard.

Once again, I don't often get a chance to address this issue before the VA. By and large, as we have set up the organizational aspects of this effort, you are to be commended. I just hope we can do it and keep the slogan that we all agree is ultimately the most important, and that is "help without hassles".

I thank you, Dr. Brown.

Dr. BROWN. Thank you, Mr. Daschle.

Mr. EVANS. Mr. Mollohan.

Mr. MOLLOHAN. Thank you, Mr. Chairman. I appreciate the opportunity to participate in this hearing, and I know it has been very helpful in bringing attention to the problem of post-traumatic stress disorder. I know it certainly has been for me and I am sure it has been for this committee generally.

I have a couple of questions for Dr. Brown regarding the study. On page 2, if you will, of your statement, Dr. Brown, you talk about a task force study. I want to get into that.

Also on that page, I am very pleased to see that there seems to be no disagreement of the need for this program. You affirm it—I think this hearing has made it readily apparent, the witnesses before you—and your testimony seems to clearly affirm that and acknowledge that the VA recognizes it and sees it as a real problem. As a matter of fact you say the same on page 2, "The VA recognizes the value of the readjustment counseling program and is strongly committed to it." I think that is very good to see because, of course, that is an important element in addressing it and correcting it.

There is some confusion in my mind, however, and I would like to explore it with you, regarding your task force study, its role, and how it affects or the continuation of this program and the extension of the eligibility period. I think there is a time bind here.

What role do you see the task force study fulfilling specifically?

Dr. **Brown**. Mr. Mollohan, the task force was appointed primarily to determine the fate of the vet center program, in view of the fact the legislation says that next April we are supposed to report to Congress on a plan to integrate the program into our usual system. The task force was appointed to evaluate all aspects of that requirement and to determine exactly how and when and what we should do in solving all the problems [illegible] thereto.

Mr. **Mollohan**. So the task force [illegible] appointed is in compliance with the statutory mandate [illegible] from the vet centers to treatment in a veterans medical facility?

Dr. **Brown**. I would state it just a [illegible] differently, Mr. Mollohan. It is to recommend to the Admini[illegible] [illegible]t we should do in regard to the future of the vet center [illegible]. They have the latitude of making any recommendations, not simply to fold it into our overall system.

Mr. **Mollohan**. You have a statutory mandate to provide the Congress by April 1, 1984, a report on how you are going to achieve this transition, and to begin fulfilling the mission here of treating this condition in the veterans hospitals.

Dr. **Brown**. Yes, sir.

Mr. **Mollohan**. Now, is that a part of this process?

Dr. **Brown**. That's a part of the process.

Mr. **Mollohan**. What part of the process is it?

Dr. **Brown**. Well, that is just one of their charges. They know that there is pending legislation, for example, to extend the program.

Mr. **Mollohan**. But is the task force the vehicle that the VA is using to make this recommendation on how this transition is going to occur?

Dr. **Brown**. Yes.

Mr. **Mollohan**. Is there any other purpose being served by this task force at the same time?

Dr. **Brown**. To assess the needs, the requirements according to our experience, and make any other recommendations that they deem appropriate to the Administrator.

Mr. **Mollohan**. So that I don't misunderstand, is the task force at all studying the question of whether or not the eligibility should be extended?

Dr. **Brown**. Yes.

Mr. **Mollohan**. It is studying that?

Dr. **Brown**. Yes, it is.

Mr. **Mollohan**. In your testimony you indicate "Although the numbers of additional Vietnam-era veterans who might seek these services for the first term after September of 1984 may not be large, this program has demonstrated its capacity to provide needed assistance and a 1-year expansion of the program * * * may be warranted."

So you have at least on some tentative basis concluded that the extension of the program may very well be warranted; is that correct?

Dr. **Brown**. Yes, sir, that is accurate. And that is based upon our experience, in that the number of clients coming into our vet centers is increasing.

Mr. **Mollohan**. So there is plenty of evidence out there at least to make a tentative judgment——

Dr. **Brown**. That's right.

Mr. **Mollohan** [continuing]. As to the necessity for extending the period in which a Vietnam veteran may achieve eligibility?

Dr. **Brown**. That's right.

Mr. **Mollohan**. Now, when do you expect the report from this task force to be completed?

Dr. **Brown**. In the fall, in September.

Mr. **Mollohan**. September of this year?

Dr. **Brown**. They will report in September to the Administrator, yes, sir.

Mr. **Mollohan**. It becomes apparent to me, then, if you are making the judgment with regard to eligibility, at least holding off making a final judgment with regard to the extension of the eligibility until the task force report comes in, that the Congress is going to be in a real time bind. We must act on this question immediately. I just want to get on the record here that you are not waiting for the task force recommendation to make a final determination on the need for eligibility because you recognize that if you waited for that final report that would be too late for this Congress to act upon the eligibility; we would have a gap, in other words——

Dr. **Brown**. Yes, sir, correct.

Mr. **Mollohan** [continuing]. On the eligibility extension.

So I understand you are, indeed, recommending and agree that some extension of the eligibility should be made at this time?

Dr. **Brown**. That's correct, sir.

Mr. **Mollohan**. So you're onboard.

Dr. **Brown**. Yes, sir.

Mr. **Mollohan**. Well, we're very pleased to hear that.

I have a couple more questions here, Mr. Chairman.

In H.R. 1443 you address the study which is proposed by this legislation at page 4 of your statement. You indicate that it is unlikely that the study required by H.R. 1443 could be designed, conducted and a report completed in the time required by the bill.

What timeframe do you suggest for the completion of this H.R. 1443 study? Of course, the importance of that is that we need to get that before the Congress within an eligibility period, you understand. So I am wondering what time period you think we need to complete that study.

Dr. BROWN. I don't know. We have not addressed this in detail by our research section to determine exactly how long it would take in order to do the study that would be mandated by H.R. 1443. We are just very sure we can't complete it in the timeframe that is in the proposed legislation.

Mr. MOLLOHAN. Well, you explore this question to some extent to come to the conclusion that you felt you didn't have time enough, is that correct?

Dr. BROWN. Yes, sir.

Mr. EDGAR [presiding]. Would the gentleman yield at that point?

Mr. MOLLOHAN. Yes, Mr. Chairman, I certainly will.

Mr. EDGAR. A bill was introduced today in the House by Mr. Evans to extend the vet center program for 3 years, The study that he has, in his bill is identical to the study in my legislation, would give you an additional year to evaluate the results and to bring back to the committee and to the Nation reaction and response to that.

Would that additional year be sufficient for you to have enough time?

Dr. BROWN. No, sir, I don't think it is. I would ask Dr. Earl Freed if he would address that. He is the Deputy ACMD for research.

Mr. EDGAR. The date would be December 1985. Unless you were going to goldplate it with a great deal of footnotes, it seems to me you would have some results by that time.

Dr. FREED. There are some technical difficulties involved, Mr. Edgar, in that the kind of study that is mandated would require the training of multidisciplinary teams to conduct interviews. It would likely be a rather lengthy study.

There was also the question of what would constitute technically a suitable control group. There was the possibility that on an existing twin study, which we began to study the effects of agent orange, we could expand the sample so that we could be looking at Vietnam service versus non-Vietnam service areas.

Mr. EDGAR. The Center for Policy Research just took 2½ years to do their study, which was of a similar nature. Why would your study take longer than that?

Dr. FREED. I am not fully familiar with the details of that study. That study Dr. Ewalt could probably give much greater detail on.

Mr. EDGAR. It just seems hard for me to understand, coming out of an academic background from a very technical university, that a study of this nature, which is critical, even with all the control groups that you would need, it would seem to me that 2 years should be sufficient, given the fact you have some data and you have some experience from past studies and have some information in place from the years that the vet centers have been in place. You have the availability of veterans that you didn't have 5 or 10 years ago. I just don't understand why it would take so long.

Dr. **FREED**. You're speaking of an additional year to that which is proposed in the bill now.

Mr. **EDGAR**. That's correct.

Dr. **FREED**. And we could initiate that study so that we would have 2½ full years; is that correct?

Mr. **EDGAR**. That's correct.

Dr. **FREED**. And within 2½ years, it is quite likely it could be accomplished, yes.

Mr. **EDGAR**. Thank you.

Dr. **FREED**. Within the present——

Mr. **EDGAR**. The gentleman from West Virginia has the time.

Mr. **EVANS**. If the gentleman would yield.

Mr. **MOLLOHAN**. Yes.

Mr. **EVANS**. I don't come from an academic background, but I do have a lot of experience with Vietnam-era veterans. They are very concerned, for example, that we never have been able to complete a study on agent orange. We have had witness after witness testify here today about the problems that people face with posttraumatic stress disorder. People in the Vietnam-veterans community need action now. They are facing problems now. I think the study should be expedited as quickly as possible.

Mr. **SMITH**. Will the gentleman yield?

Mr. **MOLLOHAN**. Yes.

Mr. **SMITH**. I just wanted to remind the gentlemen who perhaps did not catch the opening comments of John Paul Hammerschmidt, our ranking member—and I think it reflects the feeling on this sides of the aisle—that we would ask the VA to begin preparation and make it a priority that this study begin now and not wait until the legislation is passed. I think there is a concurrence on both sides of the aisle that we move ahead today.

Mr. **MOLLOHAN**. In line with that, I am concerned about part of your testimony where you say you feel its cost would be prohibitive—again, I am looking at page 4. Why do you feel its costs would be prohibitive? Don't you think that's a determination for the Congress?

Dr. **BROWN**. Certainly, sir, that is a determination for the Congress. We just felt that in order to get it done in the timeframe which we were dealing with, it would be much more cost effective to extend it out so that we could do a better job.

Mr. **MOLLOHAN**. So really your concern was the timeframe?

Dr. **BROWN**. Yes, sir, that's accurate.

Mr. **MOLLOHAN**. Along with that, and along with my colleague from New Jersey's comments, I understand that the program is expected to cost $7 to $8 million in the current fiscal year. I think you were appropriated $11.2 million.

Dr. **BROWN**. That's accurate, for the contract program.

Mr. **MOLLOHAN**. I am wondering, Mr. Chairman, if the difference couldn't be applied to initiate this study.

Mr. **EDGAR**. I think clearly we ought to take a look at that. I would be glad to work with all the gentlemen on the committee because I think it is appropriate for us to expedite it.

Are there any other questions of the members? I have some questions.

Dr. Blank, do statistics show an increase in the incidence of alcohol or drug abuse among Vietnam-era veterans coming to your program or coming to the VA in general?

Dr. **Blank**. Yes; over the past 3 years there has been a notable increase in the utilization of VAMC drug and alcohol programs both by Vietnam veterans. There is no particular increase in the numbers coming to vet centers with those problems. That has stayed about even.

Mr. **Edgar**. Can alcohol abuse be related to posttraumatic stress disorder?

Dr. **Blank**. Yes; it can. I have seen a number of cases in my own clinical experience at the West Haven VAMC, and we have now cases reported in the literature where both chronic alcoholism and chronic drug use are masking an underlying posttraumatic stress disorder.

Mr. **Edgar**. Dr. Brown, is there any research currently being conducted on the possible correlation between posttraumatic stress disorder and alcohol or drug abuse?

Dr. **Brown**. I will have to ask Dr. Freed to address that.

Dr. **Freed**. There are a number of studies on alcoholism and there are studies on delayed stress disorders. Undoubtedly, there is some overlapping.

Mr. **Edgar**. What is the VA currently spending in fiscal 1983 and 1984 on all treatment and research on alcohol and drug abuse and related medical disorders?

Dr. **Freed**. Research on all mental disorders?

Mr. **Edgar**. No; on alcohol and drug-related problems.

Dr. **Freed**. I would have to provide that for the record.

Mr. **Edgar**. Without objection, you can provide that for the record.

Dr. **Brown**. The clinical portion also, Mr. Chairman, if we may.

Mr. **Edgar**. OK.

[Subsequently, the Veterans' Administration furnished the following information:]

In fiscal year 1982, for which we have final budget data, VA supported $4.8 million of research whose primary areas were Alcoholism and Drug Dependence and $4.2 million of research whose secondary areas were Alcoholism and Drug Dependence. We will not have final fiscal year 1983 figures until the end of the fiscal year, but, in view of the fiscal year 1983 research budget restoration, we would anticipate some increase in these areas of research, and it is likely that the fiscal year 1983 level would hold for fiscal year 1984.

Concerning the clinical portion, the VA anticipates a budget outlay of $187,270,000 for all alcoholism and drug abuse treatment services during fiscal year and an outlay of $196,633,000 during fiscal year 1984.

Mr. **Edgar**. Dr. Brown, on page 6 of your statement you indicate that the integration of the vet center program into the Department of Medicine and Surgery mainstream has been accomplished. Yet in the next sentence you indicate just the opposite, that the mainstream of the Department of Medicine and Surgery is being integrated into the vet centers.

Would you care to comment on this?

Dr. **Brown**. I think Dr. Blank can address that better than I. He has a better feel for it.

Dr. **Blank**. Well, in general, I think it would be best to describe this as an ongoing process of integration, especially at the professional level, where we are dealing with a highly specialized and, if I may say, sophisticated treatment capacity on the part of the vet center staffs, situated in an innovative and nontraditional administrative structure. We are dealing with an ongoing process of mutual education and integration of that into the DMS system.

Mr. EDGAR. So it is not one being integrated into the other——

Dr. BLANK. Both systems are learning from each other.

Mr. EDGAR. Dr. Brown, some of our colleagues from the Massachusetts delegation have expressed their concern with the closing of the satellite vet center in Lowell, Mass. What was the reason for the closing of the vet center and is there a possibility that the vet center may be reopened in the future?

Dr. BROWN. Mr. Chairman, the vet center in Lowell was established as a temporary satellite in order to provide service until we could get other vet centers going. It was done because we had FTEE for new centers that we couldn't utilize and, therefore, we wanted to put the people to work as quickly as possible serving the need.

When we then opened the vet centers that are due to service the various areas, we had to pull back the temporary vet centers in order to integrate those FTEE into the parent vet center.

Mr. EDGAR. FTEE is full-time——

Dr. BROWN. Equivalents. They are positions.

Mr. EDGAR. How many vet center personnel are career employees?

Dr. BROWN. About 140.

Mr. EDGAR. If the program is to be phased into the VA medical system, what plans are being made to convert these individuals to career status as a permanent employee of the agency?

Dr. BROWN. We have had intensified focus on this problem in recent months. This matter was discussed in detail with the Deputy Administrator last week and will be taken up as number one item on the agenda of the planning task force at tomorrow's meeting. We are concerned about addressing this issue as rapidly as possible.

Mr. EDGAR. I think the committee would be appreciative, if there are any documents in the near future that relate to that plan, to just have some communication from you on how you plan to do that.

Dr. BROWN. Yes, sir.

Mr. EDGAR. Dr. Brown, you state in your testimony that the VA would look favorably on conducting certain types of research on the readjustment of Vietnam veterans on its own. Can you tell me how much money would be allocated for that project? Could you make an estimate of that amount of money, or would those funds be taken from the general VA research budget?

Dr. BROWN. Any additional study that we have to do will have to have an additional budget because the research is very tight at present.

We estimate that—what is it, Dr. Freed, $3 million?

Dr. FREED. $3 million.

Dr. BROWN. That $3 million could do a general needs assessment of the Vietnam-era population.

Mr. EDGAR. $3 million out of how much?

Dr. **Freed**. The total VA budget currently in research is approximately $150 million.

Mr. **Edgar**. Dr. Brown, I understand that VA Program Planning and Evaluation is conducting a study to survey the effectiveness of the vet centers in providing counseling services. When do you expect the results of that study to be forwarded to this committee?

Dr. **Brown**. Dr. Blank.

Dr. **Blank**. The current target dates, I believe, are early next year for a report on their administrative survey of program operations. I think in the fall of the year is when the report on their assessment of the clinical effectiveness of the vet center services is planned for completion.

Mr. **Edgar**. Has any other VA mental health or medical service received such an evaluation in recent years to gauge their outcome or effectiveness, and has this ever been done before on a programwide basis?

Dr. **Brown**. I don't know the answer to that, Mr. Chairman. I don't know if any of my colleagues do.

Dr. Ewalt?

Dr. **Ewalt**. We have had two done on the alcohol and drug programs, and there is another one ongoing on the alcohol program.

Mr. **Edgar**. How does the VA evaluate the effectiveness of any of its hospital programs? What criteria do you use?

Dr. **Brown**. Of course, there are a number of criteria we use. Quality of care is measured in many different ways. We evaluate both the service to veterans from the standpoint of circulating questionnaires each year, to see if they are, indeed, satisfied. We follow all the oversight agencies such as the Joint Commission on Accreditation of Hospitals. We have our own inhouse program with which you are familiar.

All of these are monitored in Central Office, I think there are about 26 different agencies that evaluate our various programs regularly. These are monitored in Central Office very carefully, and if there is action needed we see that it is taken.

Mr. **Edgar**. Would you say it would be wrong to characterize the evaluation on effectiveness of the vet centers as the VA singling that group out, or would you say this is just normal practice within the VA to have this type of effectiveness evaluation?

Dr. **Brown**. Mr. Chairman, that is normal practice within the VA.

Mr. **Edgar**. Dr. Brown, the DAV has suggested—and I feel it would be helpful—that you submit to the subcommittee a list of all contractors currently enrolled in the fees-for-service portion of the readjustment counseling program. Could you submit that for the record?

Dr. **Brown**. Yes, sir, we will, Mr. Chairman.[5]

Mr. **Edgar**. Dr. Blank, in your professional opinion, does a potential problem exist concerning the prevalence of posttraumatic stress disorder among active duty military personnel who served during the Vietnam era or in Vietnam?

Dr. **Blank**. It appears to me that there is an increased recognition of the existence of that problem amongst active duty personnel, especially in the last 12 or 18 months. We have had a small number of inquiries from professionals at military posts around the country directed to our vet centers asking for some consultations.

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[5] Retained in committee files.

I have also been invited to present this problem at psychiatric grand rounds at Walter Reed next month, which may be another indicator.

Mr. **Edgar**. Has the VA made any overtures to the Department of Defense under the terms of the DOD/VA sharing agreements on coordinating readjustment counseling services for these individuals, or requesting reimbursement from the Department of Defense for potential treatment which could be provided by vet centers?

Dr. **Brown**. Mr. Chairman, we have not specifically addressed that in the DOD Sharing Committee as yet. That committee is just getting organized and hasn't addressed items as specific as this.

Mr. **Edgar**. Would you think it appropriate to at least raise the question—not necessarily that you would put a program in place—but raise the question with the Department of Defense?

Dr. **Brown**. Yes, sir, I think that is quite appropriate. As Dr. Blank said, the DOD is already becoming much more cognizant of this disorder and the fact that they may have some problems with it.

I, too, conducted a clinical session at the National Naval Medical Center not too long ago on posttraumatic stress disorder—at their request, I might add.

Mr. **Edgar**. At this time I would like to ask unanimous consent to include in the record at this point an overall evaluation of the vet center operation prepared by Dr. Blank. I would like to place that in the record at this point, without objection.

[Subsequently, the Veterans' Administration furnished the following information:]

OVERALL EVALUATION OF VET CENTER OPERATIONS

After three years of development, the Vet Center operation has reached full operations as Congressionally authorized. 136 Vet Center and satellites are provided for by current dollar and FTE resources, and the 136th is to open officially on February 14, 1983. Program activity as measured by key indicators has been steadily increasing from inception to the present. Key indicators are as follows:

	New clients	Total collateral visits, family members, etc. (regardless of length)	Total visits (regardless of length)	Total contacts (visits in units of 15 minutes)
Fiscal year:				
1980	28,689	15,428	79,943	76,467
1981	45,637	34,528	207,768	1,061,478
1982	51,025	50,948	295,202	1,548,696
1983 [1]	80,000	70,000	404,000	2,000,000

[1] Figures for fiscal year 1983 are a projection based on experience in the first quarter, taking into account the time required for the 27 vet centers which have opened during the past 12 months to get to full operation.

Note.—670,000 visits, 45 minutes in length, projected for 1983.

As of December 1983, the 136 Vet Centers and satellites had been open an average of 24.7 months. 28 Vet Centers opened in calendar year 1982. As of January 1983, they had been open an average of 8.5 months. Management problems attendant upon the development of a new and innovative program, have been largely resolved. Staff turnover is less than was expected in light of the task, which 4 to 6 person teams have of counseling large numbers of combat veterans concerning war-related readjustment problems.

Concerning future plans, DM&S is appointing a Task Force to convene February 11, 1983, which will study all aspects of program operations and service needs, both present and future, and make recommendations for the future of the program. This will furnish information required for the Administrator's report scheduled for April, 1984.

Prepared by Arthur S. Blank, Jr., M.D., Director, Readjustment Counseling Service, January 21, 1983 and revised February 4, 1983.

Mr. **Edgar**. The chief counsel of the subcommittee has a number of questions that he had planned to ask. He would like to be recognized at this moment.

Mr. **Casteel**. Dr. Brown, if I heard correctly, you estimated the study would cost in the neighborhood of $3 million. On page 4 of your testimony you indicate that you expect to expend somewhere between $7 and $8 million of the earmarked $11.2 million for the fee-for-service program in this fiscal year, and you should use it all in fiscal year 1984.

What would be the reason you couldn't use the unused portion of that for getting this study underway?

Dr. **Brown**. Mr. Casteel, that is being considered by the Chief Medical Director right now, as a matter of fact. This is a recommendation that we have asked him to consider. Certainly we would have to come to the Oversight and Appropriations Committees and get their permission for using the money for that.

One issue that we would need to address is whether or not we could complete it in this fiscal year, because that money is this fiscal year's money. If we could get that money reprogramed into the research area, that would be at least 2-year money which would allow us to go over the October 1 date.

Mr. **Casteel**. Do you plan to do this study in-house or by contract?

Dr. **Brown**. More than likely by contract.

Mr. **Casteel**. If you contracted, couldn't all of the amount be obligated prior to the end of the fiscal year?

Dr. **Brown**. Dr. Freed tells me that would be very difficult.

Dr. **Freed**. I think it might be difficult between now and the end of the fiscal year to get a full statement of the work that is proposed and obligate the money in time.

Mr. **Casteel**. If the residual of this money is not used for the fee program, would you have to come to the Congress to use it anywhere else?

Dr. **Brown**. Yes, sir. My counsel says it would have to be reappropriated.

Mr. **Casteel**. Reappropriated, or approval of the Appropriations Committee to utilize it?

Mr. **Hendricks**. It would be transferring the money from the medical care funds into the research appropriation. As you know, there is limiting language in the appropriation every year that that money can only be used for the care and treatment of veterans, not research.

Mr. **Casteel**. Dr. Blank, I have a series of questions for you, but rather than ask them individually at this time, I would like to submit them to you. What we are driving at, we would like to get your personal opinion and input in answering these questions. If you will supply that for the record, we will put it in the record of the hearing.

Dr. **Blank**. I will be happy to do that.

[Written committee questions submitted to Dr. Arthur Blank and the response follow:]

Veterans' Administration,
Department of Medicine and Surgery,
Washington, D.C., May 25, 1983.

Hon. Bob Edgar,
Chairman, Subcommittee on Hospitals and Health Care, Committee on Veterans' Affairs, House of Representatives, Washington, D.C.

Dear Mr. Chairman: At the close of the VA participation at the March 24, 1983, hearing on the Readjustment Counseling Program by your subcommittee, the Chief Counsel requested that one of the VA witnesses, Dr. Arthur Blank, provide the subcommittee with his personal opinions in response to questions the subcommittee would supply the VA following that hearing.

While I certainly respect the interest of the Subcommittee in obtaining expert opinions from any VA witness, I am sure you appreciate the fact that program witnesses may have a parochial perception of their programs as compared to the operation of the entire VA system or the Department of Medicine and Surgery.

As Program Director in charge of the Readjustment Counseling Program, I would expect Dr. Blank's personal opinions to reflect the posture of the Department of Medicine and Surgery. I would also expect that only the Chief Medical Director's position on program matters can be considered the official Department position.

I believe it is unfortunate that Dr. Blank was put in this position and it is unfair of the Subcommittee to expect a program director to express views which may not be the official views of the Department. I am, therefore, enclosing answers to the questions requested of Dr. Blank for the official hearing record.

If you wish, I would be pleased to discuss this matter further at your convenience. Otherwise, I assure you of my and the Department's continued full cooperation with the committee and its subcommittees.

Sincerely,

Donald L. Custis, M.D.,
Chief Medical Director.

Enclosure.

Questions and Answers

Question 1. When was the contract program initiated?

Answer. The fee-for-service program for contracting with private sector providers for readjustment counseling for veterans was initiated by the Veterans' Administration in 1982.

Question 2. How many VA Medical Centers are providing administrative support for this program?

Answer. Of the total 172 VA medical centers, 122 are providing administrative support to the 136 Vet Centers. This support consists of determining eligibility through our Medical Administration Service and also monitoring the amounts of monies that are expended on this program through our Fiscal Service.

Question 3. How many contracts have been approved?

Answer. As of May 1, 1983, the VA has approved 409 contracts. A computer printout listing of the contract providers has been given to the committee as an insert for the hearing record.

Question 4. What is the average cost of a visit when a Vietnam veteran is seen by a contract provider?

Answer. The average cost per visit for contract providers is not yet known. The fees charged range between (in most instances) $45.50 for individual and family sessions, and $20–$25 for group sessions. Average cost per actual visit will not be available until the numbers of visits in the various categories are collected nationwide.

Question 5. How much does it cost for Vet Center staff to provide these services?

Answer. The total cost per 45-minute session, including overhead, is $30. This is an average cost for all types of visits combined—individual, family, and group. A direct comparision to contractor provider cost per visit will only be possible when additional data is received on the breakdown of contract provider visits by category (individual, family, group).

Question 6. How much does it cost for a Vietnam veteran to be seen at a VA mental hygiene clinic?

Answer. The cost per 45-minute visit (estimated) at a VA mental hygiene clinic is $42.90 for direct service provider personal services costs, not including overhead. The comparable cost for Vet Centers is $19.50 (direct service provider personal services cost, not including overhead). Cost per visit for mental hygiene clinics is not available including overhead. Vet Center cost per visit including overhead is $30.

Cost per visit differential between Mental Hygiene Clinics and Vet Centers is accounted for by several factors, including the fact that the staffs of Mental Hygiene Clinics include a large proportion of psychiatrists and a larger proportion of psychologists and psychiatric social workers than Vet Centers. These staffing differences pertain to the fact that, in contrast to Vet Centers, Mental Hygiene Clinics are tasked with the responsibility of providing a wider variety of services to veterans with a wider variety of mental disorders. Additionally, the cost differential derives from the much wider use of group counseling in Vet Centers.

Question 7. Is the Vet Center program the most cost-effective way to provide counseling and therapeutic services to this particular group of Vietnam veterans?

Answer. On the basis of currently-available data, it is clear that Vet Centers are providing their unique mix of services on a highly cost-effective basis, due to the utilization of paraprofessionals under proper supervision and the extensive utilization of group counseling. There are numerous differing advantages to Vet Center, Mental Hygiene Clinic, and contract provider services, which cannot be directly incorporated into cost comparisions.

Question 8. Is it fair to say that the contracts program is expensive to operate?

Answer. When compared to the cost of Vet Centers' service delivery, yes, that is a fair assessment. The administrative burden associated with monitoring the contracts program places additional responsibilities on the Vet Center staff. Vet Center Team Leaders and counselors, and also VA medical center professional staff members in a number of locations, must assess cases for referral, complete paperwork authorizing and reauthorizing visits, and monitor the overall flow of referrals and frequency of visits to insure that services are provided to the greatest number of veterans within fiscal limits. Operation of the program is proving to be a strain on VA medical center and Vet Center staff at some locations.

On the other hand, the contract fee-for-service program allows veterans who reside in a rural area to receive needed counseling which normally could not be provided by Vet Center staff. The contracts program is also affording the VA an excellent opportunity to interact with community medical/psychiatric professionals.

Question 9. How much administrative time is being devoted to the contract program by Vet Center teams? What is the estimated costs?

Answer. Reports from the field suggest that the Vet Center Team Leaders find the administrative functions of the fee-for-service program requires approximately 20 percent of their time in such areas as referral of clients; monitoring fiscal and clinical issues, especially the assessment of cases for referral and authorization and reauthorization of visits; and managing referrals and frequency of visits within fiscal limits. A detailed cost analysis of this administrative-professional time is not available at this time. We can only repeat that a significant amount of time is expended by Vet Center staff, and in some instances by VA medical center staff, to administer the contracts program.

Question 10. How many contracts have been approved? Do you expect to approve additional contracts? If so, how many?

Answer. We approved 409 contracts through May 1, 1983; approximately 57 new contracts should be approved within the next few weeks.

Question 11. Can the Vet Centers handle the clients who are now being served by private contractors? How much additional staff would take? What would be the cost?

Answer. Approximately 6,000 clients are currently being served by contract providers. As you are aware, the original concept of contracting out of readjustment counseling by private sector counseling providers was to improve access to readjustment counseling for veterans living in rural or remote areas, away from available Vet Centers. Whether these veterans living in remote or rural areas would travel to Vet Centers for counseling is in question and how many of them would do so cannot be currently determined.

Since, for the most part, our Vet Centers report heavy workloads currently, we presume it would be difficult for existing staff to absorb an additional workload. The numbers of additional staff which might be required to absorb any portion of contractor services have not been formulated.

Concerning the plans for this aspect of the program and all other future plans, the Chief Medical Director has appointed a Readjustment Counseling Planning Task Force. This task force has been organized into subgroups to study all present and future aspects of program operations and service needs. These groups will make recommendations to the Chief Medical Director during the Fall of 1983.

Question 12. Are the staff in the VA Mental Hygiene Clinics capable of addressing the needs of veterans suffering from PTSD? If so, are the majority skilled in this area of stress disorders? Do you believe that their level of skill is equal to that of Vet Center personnel?

Answer. At the present time, the Readjustment Counseling Service, the Mental Health and Behavioral Sciences Service, the Social Work Service, and other relevant elements, are working closely together to improve the professional skills of staff throughout the VA system, as concerns the assessment of posttraumatic stress disorder in Vietnam veterans, and the provision of services of veterans with this problem. This entails a careful ongoing assessment of cases being seen by all relevant service delivery systems, and the fashioning of numerous training endeavors, both of which are now underway.

Question 13. How many clients are being seen by Vet Center personnel who are suffering from stress disorder?

Answer. We do not currently have data upon which to base an accurate answer to this question. We anticipate that the needs assessment survey will produce data on the incidence of posttraumatic stress disorder among the Vietnam veteran population.

Question 14. How many people served in Vietnam and how many of that number would you estimate suffer from a stress disorder?

Answer. Since many people who are still on active duty served in Vietnam, I presume you refer only to the number of *veterans* who served in Vietnam. There is some uncertainty about the total number of veterans who served in Vietnam, Cambodia, Laos, and in the adjacent seas and airspace between 1964 and 1975. One current estimate is 3.4 million. Neither of the two major surveys of this population for readjustment problems (The Harris Study of 1980 and the Center for Policy Research Study of 1981) carefully measured the occurrence of posttraumatic stress disorder, per se. They did gather detailed information on various measures of stress and readjustment problems which are thought to be related to stress disorder. It is therefore necessary to evaluate the results of those studies in detail and also to interpret their data at length in order to estimate the number of Vietnam theatre veterans who may currently show stress disorder. Since more recent data is available, it is hoped that the projected needs assessment project of this population will provide further data.

Question 15. What would be your personal recommendation as to how Congress should respond to the numbers of Vietnam veterans suffering from PTSD?

Answer. Whereas some Vet Centers are currently experiencing caseloads which indicate that siting and staffing are adequate to meet the needs of Vietnam veterans in their areas, there is reasonable question about a possible need for staff expansion at some locations and the need for additional Vet Centers in other locations. Our present experience with this program indicates that utilization by veterans will remain at its present high level and may increase in the years immediately ahead. The currently-authorized 567 FTEE may not be sufficient to meet the demand. Some extension of authority to provide services in this area appears to be needed.

Until the needs assessment project is completed, my personal comments can only reflect my guess as to what the workload out there might be. Once the project data begins to come in and we are able to identify trends, we may be able to make preliminary projections to support recommendations to Congress. At this point, I would recommend that a congressional response to the number of Vietnam veterans suffering from PTSD is premature. We would anticipate that both administrative and legislative recommendations would result from the collection of data for the needs assessment project.

Mr. **Edgar**. Thank you.

Before dismissing you as a panel, I want to compliment you on your patience this morning. The hearing has gone very long. It takes some time to get into some detail of this issue.

Let me state what I believe is going to happen for the record. We are going to extend the readjustment counseling centers for 1 year, 2 years, or 3 years. The decision on which of those three approaches will have to be made, but in talking with John Paul Hammerschmidt and others there is an interest at least in a minimal extension and possibly a stronger interest as a result of today's testimony in a 3-year or 2-year extension of the readjustment counseling centers. This says to me that the phasing out of the centers will not actually happen on the schedule that is in present law.

Second, it is clear to me that there is a great deal of interest in the study that we talked about. You have provided us with good, strong testimony on the need for adequate time so that a thorough investigation can be made.

We have now suggested that whatever approach, 1, 2 or 3 years, will give you a longer timeframe to do the study. As my colleague from New Jersey has indicated, we are hopeful that you might begin to think, to plan, to ask some questions, and perhaps have a dialog with the committee and its membership, particularly the chairman and ranking Republican, on the ingredients of that study.

Let me say, as someone who has been here for 8 years and has served on this committee and has watched the VA, you have a very good track record for providing services generally across the country. You have a very good track record in terms of your research and ability to, in some cases win Nobel Prizes, and in other cases have a good reputation around the country in terms of conducting adequate research and providing quality health care.

You have a lousy record when it comes to doing studies. I don't know whether it is because you want to make them so perfect that it takes that time, but other agencies and other committees on which I serve are able to take very complicated issues and do a pretty good job of evaluating and studying them in a timely fashion. That is not to say that studies shouldn't take any time or that we should put them together in 1 month or 2.

When the action was taken because of your delays to move one of the agent orange studies to the Centers for Disease Control in Atlanta, we know that part of the delay came from OMB and part of the pressure came from concern over the potential costs for these studies. But I really think this is a good signal to be telegraphed now to the VA in advance of getting a law put on the books that when we want a study done, you should be on notice that you have a timeframe, and that timeframe starts now.

It would be a good thing if 3 years from now, after this study is produced, we could all compliment the VA for the speed and accuracy and depth of their study, even if the information you bring back doesn't satisfy every member of the committee, but that, in fact, you have done the protocols and you have done the evaluation and had all the test groups and you have kept on that timeframe.

I would hope that your enthusiasm in doing the study, which may be small today, will, in fact grow, and that you will see the study as an opportunity to really prove that the VA can, in fact, study itself and its clients and give good, accurate information to the Congress of the United States so that we can make judgments on further needs within the system.

It would be tough for us to give a 2-year extension, for example, of the vet center program, and mandate a study and have that study come back after we have shut down the system. The reason for the study is to find out what other kinds of things the VA needs to be doing to care adequately for the problems that relate to the Vietnam era veteran.

I hope I'm not talking out of school, but I just wanted to leave you with that note and hope that the quality of output on studies will match the quality of research and the quality of health care.

Dr. BROWN. Mr. Chairman, we appreciate your critique and your advice.

Mr. EDGAR. I have no further questions. Thank you very much for your testimony this morning.

Mr. Christopher SMITH. Mr. Chairman, before we proceed, I would like to address the committee for a moment.

There have been some references made today regarding the Grace Commission report and the possibility of the administration suggesting that the VA in some way be dismantled. I would like to put that to rest.

I have a press release that was just handed to me by Rufus Wilson, our counsel, and I would like to read it into the record so that we can put to bed and put to rest any of those fears that may have been generated in this hearing.

> For Immediate Release. In response to requests from news media for comments on reports that the Grace Commission had recommended the elimination of the Veterans' Administration, Administrator of Veterans' Affairs Harry N. Walters made the following statement—and I quote:
>
> "A draft report from a voluntary group is no basis for speculating that serious consideration would be given to eliminating the Veterans' Administration.
>
> "When the President appointed me Administrator of Veterans' Affairs, he charged me with being an advocate for veterans and veterans programs. He recognizes that VA fulfills an irreplaceable role in the lives of millions of veterans and their families.
>
> "The roles and missions of the Veterans' Administration have been reaffirmed by every Congress for the past 50 years, and there is certainly no indication that the law of the land is likely to be changed regarding this nation's commitment to veterans."

Mr. EDGAR. I want to thank my colleague from New Jersey for reading that statement into the record and for clarifying it. I hope that statement is also shared with the President of the United States. I recognize that sometimes when draft reports are made available that they have misinformation. I think at this point it is important to clarify that.

I thank the Veterans' Administration for their testimony today.

We still have a number of witnesses, and some have come some distances to testify. If we are brief with you, it is not that we don't feel your testimony is important. It is simply that the pressure of schedules is making many members leave.

Our next witness will be John P. Wilson, Ph. D., Department of Psychology, Cleveland State University, Cleveland, Ohio. Dr. Wilson, thank you for coming this morning, and thank you for sitting through our hearing and listening to the other witnesses. The full text of your statement, without objection, will be made a part of the record. We invite you to summarize and raise those points that you have in your statement which are different than points that have already been made.

STATEMENT OF JOHN P. WILSON, PH. D., DEPARTMENT OF PSYCHOLOGY, CLEVELAND STATE UNIVERSITY

Dr. Wilson. Thank you very much, Mr. Chairman. It is a pleasure to be here again.

I want to address my remarks this morning to the issue of areas of future research regarding post-traumatic stress disorder as it relates to Vietnam veterans.

To begin, I want to comment that I think we are just beginning to learn about the nature and dynamics of post-traumatic stress disorder. If one reviews the literature of this disorder as it appears in the survivors of the Nazi Holocaust, Hiroshima and other victims of, say, naturalistic disasters, one thing emerges very clearly, and that is that the process of post-traumatic stress disorder is a reactive and transformative process in the life cycle of the individual, and it is one that does not get resolved easily. With respect to that, then, I think we need to look at a number of issues regarding Vietnam veterans that must be addressed in my view to fully understand the nature and course of post-traumatic stress disorder.

The first one has to do with life-span developmental research. In my earlier research I suggested that because of the configuration of personological and stressor variables experienced in Vietnam, the identity of the veteran would be permanently altered and ever-changing due to immersion in the death experience in combat. Clearly, longitudinal studies are needed to assess the many ways veterans have been affected by their war experiences. This should include assessment of PTSD and its vicissitudes over age-related stages of ego development.

I submit, based on a careful review of the literature, that the assumption that survivors return to their old personality styles after a trauma is not only false but one manifestation of the denial process in society.

Post-traumatic stress disorder is a transformative psychic process, but we do not know how long it takes individuals to assimilate catastrophic stress into the self. Further, I believe that it is equally important to understand the character strengthening qualities which emerge in Vietnam veterans as they gain a positive resolution on their war experiences.

Second, we need to understand the relation of post-traumatic stress to physical diseases and illnesses. If one looks at the good research on World War II and Korea veterans, there is a demonstrated link between stress syndromes and proneness to certain disorders, especially ulcers, hypertension, and many other diseases. At present we know virtually nothing about the relation of post-traumatic stress and the epidemiology of these kinds of stress-related disorders in this population of men.

Third, we need to understand the relation of post-traumatic stress disorder to family problems and impaired psychosocial functioning. Since most Vietnam veterans now are married and have begun raising families, the issue of how PTSD affects the family systems must be studied in great depth. This is especially important since the literature on the Nazi Holocaust has taught us that the effects of catastrophic stress can become transgenerational. Specifically, then, if a veteran suffers from PTSD, how does it impact on the entire family system? Do the spouse and children themselves exhibit stress disorders and related problems because of the father or mother's PTSD? Clearly these and many other related questions constitute vital areas of research regarding the impact of PTSD on the family.

Fourth, we need to understand the prevalence of PTSD among female Vietnam veterans. In particular, the neglected minority, in my opinion, have been those nurses and other personnel that served in the MASH units. They deserve special consideration. We have at present some clinical evidence to suggest that female Vietnam veterans have a higher incidence of sexual dysfunctions as a part of the syndrome. Additionally, there seems to be evidence that suggests they have had special problems associated with impacted grief, loss and trauma in the care-providing role of a nurse or others who worked in MASH units.

Fifth, I think it is critical that we study the relation of post-traumatic stress disorder to suicide. For many years now, outreach workers and clinicians treating Vietnam veterans have been greatly alarmed by the seemingly large incidence of suicide. Unfortunately, there does not exist at present a comprehensive study to document the prevalence of suicide among Vietnam veterans. I believe that such a study is critical and long overdue. If, in fact, the prevalence of suicide is higher than matched cohorts, identification of the relation of PTSD and service in Vietnam to such acts must be understood in order to design effective intervention strategies.

Sixth, the relation of post-traumatic stress disorder to criminal behavior. In a recent research project of mine with my colleague, Dr. Sheldon Zigelbaum of Boston, we have begun to establish the link between PTSD and violent and nonviolent criminal behavior. Our research and forensic experiences strongly suggest that Vietnam veterans who have committed crimes did not exhibit significant pre-morbid pathology, nor a criminalogic core set of characteristics. A national study of incarcerated veterans should be undertaken to determine the causal variables associated with the disposition to engage in criminal behavior. Clearly, if a strong link can be established between PTSD and the disposition to commit criminal acts, then outreach efforts can be initiated to stem the destructive process for the veteran and society.

Seventh, is the need to evaluate the effectiveness of the readjustment counseling program. So far, as we have just heard today, all of the data gathered on on Operation Outreach on readjustment counseling suggests that it has been an effective, cost-efficient program. However, as is the case with most good programs of this type, they tend to evolve new organization needs. I believe that the readjustment counseling program should be carefully evaluated against the number of criteria of program success. Further, new areas of service delivery should be studied as well. This includes, among other things, increased funding and manpower, improved and more frequent training of outreach workers, and as Dr. Kolb and others have suggested this morning, applying the research findings on post-traumatic stress disorder to the issue of full recovery of the veterans to mental health. Finally, I think we need to also consider how the vet centers could offer multimodal therapies on both a short- and long-term basis.

Eighth, the relation between exposure to agent orange and PTSD also needs to be studied. The growing concern of potential dioxin poisoning among Vietnam veterans necessitates that a study be directed to identifying the interactive psychophysiological mechanisms between exposure to the herbicidal agent and stress response symptoms. Beyond its intrinsic medical and psychological importance, such a study would have strong implication for the genetic and transgeneration consequences of exposure to dioxin compounds.

Ninth, if we are going to conduct a national study, an additional study on post-traumatic stress as it affects Vietnam veterans, we need some good scientific measures of the disorder. At present, as far as I know, there is only one measure available to specifically assess the symptoms of post-traumatic stress disorder, and it is one that I developed with a graduate student of mine in 1980. There are few other clinical scales available, and none of them directly tap the core process, that is, the reexperiencing of the original trauma. Therefore, if scientific study is going to proceed, I submit that it is necessary to develop a valid and reliable test that attempts to relate the symptoms of the disorder to specifiable antecedent stress or criteria.

Tenth, there are many other issues that need to be addressed in terms of future research. Since my time is brief, let me list a few of them that come to mind at this time:

First, I think we need to assess the special needs of disabled veterans and study the prevalence of PTSD in this population. At present, as far as I know, there is virtually no study that has looked at the issue of severity or prevalence of PTSD among disabled veterans.

Second, I think further research is necessary to try to specify the link between the effects of combat on economic success in comparison to matched cohorts. The Center for Policy Research Study presented some preliminary findings in this direction.

Third, the study of PTSD and stress syndromes needs to be looked at in terms of its relationship to premature aging and to identify individual veterans who may be at high risk for such diseases as cancer, strokes, and other serious illnesses. Such research was undertaken for the veterans of World War II and Korea, and what we have when we examine that research is strong suggestive evidence that the more severe the PTSD, the greater the risk to combat veterans for these kinds of illnesses.

Fourth, the interrelationship between social policies and the societal attitudes and the problems of veterans deserves a great deal of attention.

Finally, in my view, all of the issues that I have presented today, as well as many more, I think need to be examined within a value-moral-political context in which we come to grips with the meaning and consequences of war, not only for Vietnam veterans, but for ourselves and society.

Thank you.

[The prepared statement of Dr. Wilson appears at p. 148.]

Mr. Edgar. Thank you very much.

As I read and reviewed your statement and listened, I have to say to you that your comments are very detailed and go to the heart of the matter of what, in fact, should be included in a study. I want to congratulate you for that.

Let me ask you a couple of specific questions. The design of the study called for in H.R. 1443 would require that the investigators evaluate any possible link between post-traumatic stress and related stress disorders and the physical health of the Vietnam era veteran.

What is the current status of research in this area?

Dr. WILSON. Well, there are some studies that are being undertaken, if one looks at the literature to try to relate post-traumatic stress or other stress syndromes to psychosomatic components or physical components. But by and large, at present our knowledge is almost nil as to a scientific or medical relationship that is reliable between those. We just don't have enough information.

Mr. EDGAR. From your professional experience, do you believe that prolonged, unresolved stress can have an impact on the individual's physical well-being?

Dr. WILSON. There is no question about that. If you look at the literature on World War II and Korea veterans—and there is big literature that documents this relationship, including studies done by the VA, 20- and 30-year followup studies of World War II veterans—there is a direct causal relationship between the severity of the stress syndrome and proneness for certain physical illnesses, particularly hypertension.

Mr. EDGAR. Dr. Wilson, the Center for Policy Research Study, "Legacies of Vietnam," was published in 1981 based on cumulative data on the Vietnam era veteran population which was gathered over a 2- to 3-year period prior to that.

Would you consider the study called for in the bill under consideration today, H.R. 1443, to be redundant or duplicative of the 1981 study?

Dr. WILSON. In some ways it is and other ways it is very different. Let me point out a couple of ways that I think it is critically different from the study that is proposed in the bill.

The Center for Policy Research Study gathered its sample in two waves. Basically, the men were interviewed starting in the mid-1970's and concluded in the later 1970's. In one sense, that sample now is very outdated. Second, when that study was developed and carried out, the sophistication in some areas of our research methodology and technology around assessing PTSD is not as great as it is today.

In particular—and I don't mean to be critical of that study; in fact, I was on the NIMH team that evaluated it; it is a good study. But in particular, the measure of PTSD they used I think is very inadequate now and we need more sophisticated measures. Beyond that, we don't have the interface, the link, the scientific relationship between post-traumatic stress disorder in that study and many other areas where we need to understand its relationship to psychosocial functioning.

Mr. EDGAR. I think what you're saying is, comparatively, it still would be very important to have a new study that would deal with the issues you raise in your testimony, and give us some points of information to compare with the earlier information that we have?

Dr. **Wilson**. One of the the things that I think is critical, when we talk about post-traumatic stress disorder among Vietnam veterans, or survivors in general, is to look at what the assumptions are about the nature of the disorder.

Until recently, in the medical literature the assumption was that if one was exposed to an extremely stressful event, a catastrophically stressful event, that the person was supposed to get over that event in a short period of time, say 6 months. In fact, if you look at the research literature, if you look at the empirical evidence, the statistics are to the contrary. Individuals do not get over catastrophic stress in a short period of time. It may take a lifetime to assimilate it.

So what that implies to me is that there is, in fact, the generalization from the extant literature, that then we need to study how post-traumatic stress disorder transforms, how it changes over the life cycle of the individual.

With respect to Vietnam veterans, I think this is critical because they are now at midlife. The mean age of the Vietnam veteran is somewhere around 36 years old. So there may be some changes and perhaps some aggravation of the disorder as one moves into later tasks in adult life.

Mr. **Edgar**. One of the coalitions in Congress that I happen to chair is called the Clearinghouse on the Future. As part of that clearinghouse, we are trying to get the committees and subcommittees of Congress which have immediate agendas to look beyond their 2-year and 6-year mentalities and find out what is happening in our society.

Let me ask you a general question. Given what you know of the Vietnam era and its results, what kinds of future things should we be looking for in terms of trends and trend analysis as we go through our extension of readjustment counseling centers, as we deal with the research that is involved. What would be some of the future handles we might want to consider?

Dr. **Wilson**. With respect to Vietnam veterans?

Mr. **Edgar**. With respect to Vietnam veterans.

Dr. **Wilson**. I think there are a couple of things. One is, these individuals I have seen in my clinical practice, many men who now have families are troubled about the fact that their war experiences spin off, in effect, to the family members. For example, men will tell me that their children are afraid of them, or that the children pick up on their anger, or the children pick up on their grief that they can't express, or the stress disorder can impact on an inability to have satisfying intimate relationships, the tendency to be isolated or to have conflict, or fear of getting close.

So again we come back to the critical point. We have a population of people now at midlife faced with the task of raising children, having a family, and then assuming other kinds of responsibilities as they move into the late thirties. I speculated in my early research before this and the Senate committee, that the midpoint, the peak at which we will see the highest incidence of PTSD, that is won't begin to reach an asymtote, to flatten out, until the mid-eighties. So my best guess would be that we're going to see an increasing prevalence of post-traumatic stress disorder among Vietnam veterans through the 1980's and possibly into the 1990's.

Mr. **Edgar**. Thank you very much.

Mr. Smith?

Mr. **Christopher** H. **Smith**. Thank you, Mr. Chairman, and Dr. Wilson.

You say a great deal in a very short period of time and you choose your words very carefully. I call attention to the committee of your simply-stated definition of PTSD, which is a reactive transformative psychological process in which the survivor attempts to assimilate the profoundly stressful event into an ordered, meaningful perspective that is consonant with his or her most basic beliefs and values.

My question, in speaking as you do as to what causes post-traumatic stress syndrome, you mention three items—combat role factors, exposure to specific stresses in Vietnam, and psychological isolation at the homecoming.

Dr. **Wilson**. Correct.

Mr. **Smith**. Yet you talk about the most basic beliefs and values. I wonder if in your study, or any proposals in subsequent studies, future studies, the relationship between a veteran who has a strong faith in God, be it Jewish, Christian, or whatever, versus the veteran who had not really come to any conclusions about the true meaning of life, has ever been brought to bear in those studies.

I am saying that, in the most formative stage of 18 and 19, when so many of us were questioning "why am I here, does God even exist"—and many of us could be characterized as agnostics at that point—and then some time in the future we came to some of other conclusions, and yet the veteran at that time was faced with this most traumatic experience, what has been the relationship that you have found?

Dr. **Wilson**. Well, I didn't find much when I asked questions of religious affiliations. If you look at traditional demographic and sociological kinds of variables that describe those kinds of beliefs, one doesn't find that they relate very well to the prediction of post-traumatic stress disorder. That doesn't imply that they don't necessarily.

As I understand your question, one of the things we need to learn is this: How come some men come through combat OK? How come some men don't come through combat OK and end up with post-traumatic stress disorder or some other form of psychopathology?

I would submit that in the next wave of research studies that could be done, that a careful design be constructed to try to get measures, to put in some probes that would identify personological variables, factors in the self, the individual, that may, in fact, be predictive of the onset or the severity of post-traumatic stress disorder.

One of the things I indicated in my written testimony is that in my latest research study, on a national sample of combat veterans participating in Operation Outreach, premorbid measures do not predict very well the severity of the different dimensions of PTSD.

I think the one measure that did show the most promise was the one that you are sort of suggesting; that is, if you get a handle on was the person struggling to form their personal identity, were they struggling to try to get a coherent world view, an ideology or some system of values by which to live and organize their life, measures of that process seem fairly predictive of PTSD. What that suggests to me is simply this: That when you have a person that goes to a guerrilla war like Vietnam, who brings that fragile process of identity formation to the combat scene, he then is at risk. He is vulnerable because those stresses will impact on that natural developmental process and can then break it apart in such a way that it is fragmented. It may take a long time before it integrates again.

Mr. SMITH. Doctor, your comments are well taken.

In my own mind I have often felt that a draft age of 18 and imposing that kind of potential for trauma upon those who are the least able to deal with it, that maybe a study of this kind could perhaps point to some changes in the way we do business with the military. If there is a burden to be borne, those who can best deal with it ought to be put in those positions.

I would also make one comment, that perhaps the study may reveal, too, what may be the best cure. We find that coping mechanism that has allowed these veterans to go through a difficult situation, to prioritize it in their minds and deal with it and come out with some conclusion as to how to cope with it, that could signal a cure that perhaps our vet centers and our VA could adopt and make part of their program.

Dr. WILSON. I would like to comment on that, if I could.

One of the things we found in the most recent study is that the single best predictor variable of post-traumatic stress disorder, as I indicated in the written statement, was the degree to which the individual felt psychologically isolated when he came home from the war. In our questionnaire we asked the individuals to tell us about how they felt the first 6 months back from Vietnam. That makes a good deal of sense to me, because as we all know about the nature of the homecoming process, it exacerbated the process of isolation.

Now, what the vet center program is doing is precisely undoing that. It is building cohesion, it is building unity through rap groups, through counseling, and re-creating a significant community so that the veteran is no longer isolated. I think that is an interesting and important finding to address and to study in the future, and also try to assess this factor of isolation upon homecoming. It is not just the stresses of the war. One has to ask the question of what the reentry environment is like for someone who has gone through catastrophic stress.

Mr. CHRISTOPHER H. SMITH. I think Craig Burnette made a good point of that in his concluding statement when he talked about the Marine who said "I have finally come home". I think it was in 1983.

Thank you for your comments. I appreciate your statement.

Dr. WILSON. Thank you.

Mr. EDGAR. Are there any other questions of the witness? If not, thank you very much for your testimony.

Dr. WILSON. Thank you.

Mr. EDGAR. The next witness will be Harris Stone, executive director of Jewish War Veterans. Mr. Stone, your whole statement will be made a part of the record, without objection. We appreciate your patience this morning. We would ask that you summarize your testimony as appropriately as your can.

STATEMENT OF HARRIS STONE, EXECUTIVE DIRECTOR, JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Mr. STONE. Thank you very much, Mr. Chairman. We deeply appreciate being here to add our voice to what we have heard this morning. We are in full support of continuing this very important readjustment counseling program.

We can talk to it firsthand, because we have been participating in many of our areas by having our people volunteer and work with the persons that are doing the counseling. We think it is one of the most productive, realistic, and honest-to-goodness programs that will guarantee the return of many of these veterans who have been lost to our society.

Of course, we want to add the fact that we give support to your bill or any others with similar intent. We, too, would agree that the counseling program should be extended for more than 1 year, at least 2 or 3.

We have put in the record our statistics and what we feel about continuing this valuable program. I really think that is sufficient in view of the time, Mr. Chairman.

There is only 1 thing I would like to add, quite aside from our testimony on this particular bill. We, too, read the Washington Post this morning and we, too, feel the Grace study of the VA is completely out of context and irresponsible. I have been in Washington long enough to know that these trial balloons can very often come forth and bite you. I certainly appreciate the Veterans' Administrator's statement to that effect, but I don't think it is sufficient, unless a committee like this backs it up and makes sure it doesn't happen.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Stone appears at p. 158.]

Mr. EDGAR. I appreciate your statement and the brevity of your statement. I have no specific questions. I join you in being concerned about that as a trial balloon. Our colleague from New Jersey I think carefully clarified the Administrator's statement. I think that statement reflects the views of many members of this committee.

Are there any questions for this witness? Thank you very much for your testimony.

Our next witness will be Mr. Paul Egan, Deputy Director, National Legislative Commission, accompanied by Mr. John Sommer, Deputy Director, National Veterans Affairs and Rehabilitation Commission of American Legion.

Gentlemen, we are pleased that you are here. We ask you to summarize your full statement. Your full text of your statement will be made a part of the record.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF PAUL S. EGAN

Mr. EGAN. Thank you, Mr. Chairman.

Nothwithstanding your intention in this instance to be a bit on the conservative side by recommending only a 1-year authorization, on the basis of what we have heard today, it seems very much in order to ask whether, indeed, 1 year is enough. There are two reasons for that. This legislation that you have introduced also calls for a study of PTSD. We would have some question as to whether or not that study could be completed before the one year reauthorization was completed.

We would certainly hate to see that study concluded, too late to have saved the vet center program.

The other matter is——

Mr. EDGAR. If the gentleman would yield at that point, the gentleman and others have convinced me that my bill is not a good bill, and I am really persuaded that either Mr. Evans or Mr. Mica have much more wisdom than I did when I introduced that legislation. But I thank the gentlemen for——

Mr. EGAN. You choose not to be a conservative in this instance, is that it?

Mr. EDGAR. I choose not to be a conservative in this one instance.

Mr. EGAN. The other point that needs to be made here is that while the vet center program is a readjustment program, it has taken on some additional functions which are also very important to its operation. That includes its function as a resource for people in need of employment counseling. We know that in probably more than 75 centers there are disabled veterans outreach program specialists there. If after 1 year of reauthorization the vet center program was terminated, what would happen to those people? Where would they go and how would they satisfactorily complete their obligations under the DVOP program? I think that is something that is important to recognize and we certainly hope, in its decision to reauthorize the vet center program, that that is weighted.

After having said that, John Sommer will summarize the balance of our statement.

STATEMENT OF JOHN F. SOMMER, JR.

Mr. SOMMER. Thank you, Mr. Chairman.

Mr. EDGAR. Again, your full statement will be made a part of the record.

Mr. SOMMER. Thank you.

The American Legion has found that the vet center program is doing well in accomplishing the purpose for which it was established. Our field service representatives visit the vet centers during site visits to the VA medical centers throughout the country and their reports are complimentary of the program and contain positive comments in the vast majority of instances.

According to some experts, as you have heard from earlier witnesses, we have only seen the tip of the iceberg in comparing the number of Vietnam veterans who have sought counseling for PTSD with the total number who actually incurred at least some symptom of the condition.

The American Legion believes that an extension of the vet center program is in order. Our belief is based upon the continuing influx of Vietnam veterans seeking assistance through the vet centers; the fact that there have been recent changes in the leadership of the readjustment counseling program which has led to the improvement of services, and that some of the vet centers have been operational for less than a year; as well as the previously mentioned findings by some mental health professionals that a much higher number of Vietnam veterans than originally estimated are suffering from some symptoms of post-traumatic stress disorder.

We feel that the study proposed by H.R. 1443 would provide an updated and accurate assessment of the current psychological and physical health status of the Vietnam veteran population, and a basis on which the Veterans' Administration may plan immediate and future treatment modalities and outreach activities. We would certainly support such an effort.

The last comprehensive study of the readjustment of Vietnam veterans was accomplished through contract with the Veterans' Administration by the Center for Policy Research, as was mentioned earlier. Subsequent to this study much has been learned about post-traumatic stress disorder and the influence of its symptoms on Vietnam veterans, their families and friends.

Audie Murphy once said that you really never get over war—you really never do. A majority of Vietnam veterans seemingly made a successful transition from the hostilities of combat back into civilian society. It was discovered early on that others were undergoing serious readjustment difficulties brought on by posttraumatic stress disorder and other physical and psychological problems. However, it was recently found that a significant number of those Vietnam veterans who had appeared to have made a rapid readjustment are now manifesting varying degrees of difficulty which are delayed reactions attributable at least in part to their military experience.

With respect to the issue of diagnosis and treatment of PTSD in VA medical care facilities, the Legion has been evaluating this situation since early last year. Our field service representatives are taking a close look at the provision of treatment for PTSD during their site visits to each VA medical care facility and they provide us with a detailed report of their findings upon the conclusion of their visit. What have we found thus far is a great deal of inconsistency.

Another disturbing conclusion that has been drawn from the site visit reports, as well as complaints from our Department Service Officers, is that many VA physicians have differences of opinion regarding posttraumatic stress disorder, including the diagnostic criteria and credibility of a PTSD diagnosis, as has been pointed out in earlier testimony.

We have seen cases, particularly during disability evaluation examinations for compensation purposes, where, for instance, although the veteran exhibits symptoms such as recurrent dreams about being killed in Vietnam, startle response, limited social or interpersonal relationships, et cetera, et cetera, the examining physician arbitrarily states that there is no evidence to support a diagnosis of PTSD.

Our field representatives have been advised by some VA physicians that in their opinion the rating boards are not fairly and objectively evaluating PTSD claims, where a diagnosis has been established. To the American Legion, these situations are serious and intolerable.

In conclusion, Mr. Chairman, the American Legion will continue to monitor all activities relating to the handling of posttraumatic stress disorder by both VA medical care facilities and the regional offices. It is our intention to present to VA officials specific instances where perceived deficiencies or discrepancies exist in the diagnoses and rating decisions pertinent to claims of Vietnam veterans who feel they have incurred PTSD. Our field representatives will also continue their evaluation of the treatment of veterans diagnosed as suffering from this disorder. The American Legion insists that these Vietnam veterans who continue to bear the burdens of their war service are to be treated in a compassionate and objective manner.

Thank you for the opportunity to present this summary, Mr. Chairman.

[The prepared statement of the American Legion appears at p. 161.]

Mr. EDGAR. Thank you very much.

Mr. Egan, you mentioned there is a close link between the job search and the economic factors and the psychological factors in the readjustment counseling centers. Do you feel that additional research is needed in the area of looking at both economic and psychological needs for Vietnam era veterans?

Mr. EGAN. Absolutely. You can well imagine that someone that comes in with post-traumatic stress or some other psychological readjustment problem, you might help that person to a point. But beyond that point, if there is no place for that person to go to work, no place for that person to support himself, that certainly isn't going to contribute to his overall recovery. In that regard we would have to agree, yes, indeed.

Also, we would hope, recognizing the involvement of the DVOP program in the vet center, that the task force report would have some explanation of how they would anticipate restationing or what other facilities they might make available to those DVOP specialists.

Mr. EDGAR. One of the things that has come to my mind as we have been listening to this testimony is that in 1973, 1974, and 1975 as we were shutting down the Vietnam conflict, until today, our whole society has been in a post-traumatic stress syndrome in terms of energy and unemployment and small- and medium-sized businesses having a difficult time, with interest rates and inflation. I think there is some connection in terms of the survival needs through an economy that is also in distress at the same time that many people are feeling psychological pressures from their service in Vietnam.

I have no further questions. Are there questions?

Mr. CHRISTOPHER H. SMITH. Yes, Mr. Chairman.

Thank you for your comments, gentlemen.

In looking on page 7 of your testimony, I note that you say some medical centers have no specific treatment programs for PTSD. Now, I understand that the Central Office has issued instructions that require that there be specific treatment programs and a criteria, and you go down further and say—and this really disturbs me—that one of your conclusions from your on-site inspections has been that there have been differences of opinion regarding post traumatic stress disorder, including diagnostic criteria and credibility of a PTSD diagnosis, and some physicians seem to be saying that they don't even think it exists.

I can understand why there might be some problems since this has only been recognized for a couple of years and some doctors not coming around. But since it is clear that the VA has mandated this, as well as developed criteria—my question really is, how widespread is it, and could you provide this committee with a report or a conclusive statement or a summary so that we could really get a handle on the situation?

Mr. SOMMER. Mr. Smith, we would be more than happy to provide you with copies of the material that we have.

We instructed our field service representatives in early October of 1982 to take a close look at the manner in which this is being handled and to furnish us with a separate report upon their return from their site visits. It is difficult at this point to say exactly how widespread it is, because we cover approximately 65 VA medical centers a year. We do get some information from our department service officers on this issue, as well as our field representatives, but we would be more than happy to provide the subcommittee with the information we have.

Getting back to the first part of your question, one of the earlier witnesses who was associated with the Veterans' Administration made a point much clearer than I could, that some physicians who received their medical training some years ago don't or aren't too quick to recognize new diagnoses or problems that are brought about at this point in time, and we would hope it is not widespread. But we will be making a determination of that.

Mr. EGAN. Could I just make one comment?

It would seem to be easy to assume that various physicians within the VA system simply don't recognize posttraumatic stress syndrome out of some hostility to the Vietnam veteran. But I think, perhaps more appropriately, it is important to recognize that the very recognition of posttraumatic stress disorder and its identification and definition is in the very infancy of its development, which further underlines the importance of this study that is anticipated by this legislation.

Mr. CHRISTOPHER H. SMITH. Thank you, Mr. Egan and Mr. Sommer.

Without objection, I would ask that when the summary is provided to us that it become a part of the record.

Mr. EDGAR. Without objection, so ordered.

Mr. Bilirakis?

Mr. **Bilirakis**. Mr. Chairman, it has been a long day, but I would like to make a statement. This statement is intended for the Chair and the committee, as well as for the veterans' groups. The reason I would like to do it now rather than at the end is that apparently many of you testify and go out the door.

I have heard most of the testimony, though not all of it, because I had to go to the House floor to make a little presentation, as did our chairman. The bottom line is I am convinced of the need for this care. I would disagree with your written testimony about the 1-year extension. I think that certainly is in order, but I personally think it ought to be an expanded extension.

The second point—and this is disturbing to me. I am a past post commander of the American Legion. I had a term for 2 consecutive years. I have attended meetings before and after and attended meetings with the VFW, and I don't recall—and I stand corrected if it has taken place—emphasis by the organizations themselves on encouraging the use of the facilities that we now have. The written testimony on behalf of Commander Zwaik is to the effect that only 20 percent of the estimated 700,000 or 800,000 Vietnam vets who needed readjustment counseling have used the vet center raises a question. The bottom line question, I think, in addition to an extension, and maybe improvement, is, how can we encourage heavier use of these facilities?

I am not asking for your answer here today because of time, but I am asking for an answer from your organization, from the VFW, from the DAV, the Jewish War Veterans, and the Vietnam veterans. What are you doing to encourage better use of these facilities? And to supplement and complement what you may be doing and what you are planning to do? How can we as a committee, and how can the VA as an organization or as a department of Government help you to supplement or complement your plans in order to encourage the use of these facilities.

I am not asking for the answers, Mr. Chairman, in the interest of time. But I am asking for them to be made a part of the record subsequent to today. I am asking this question of all the veterans' organizations that are in this room.

Thank you, Mr. Chairman.

Mr. **Edgar**. Without objection, we will make that request of each of the various organizations.

Mr. **Sommer**. The American Legion would be more than happy to provide you with that information.[7]

Mr. **Edgar**. Thank you very much.

I have no further questions. I don't think we have any further questions here. Thank you for your testimony.

Mr. **Edgar**. Mr. Stephen Edmiston, Associate Deputy National Legislative Director of the Disabled American Veterans is here. We thank you for waiting and being patient. We appreciate your statement. The full text of your statement will be made a part of the record, without objection.

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[7] See p. 177.

STATEMENT OF STEPHEN L. EDMISTON, ASSOCIATE DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. EDMISTON. Thank you, Mr. Chairman. It is a pleasure to be here this morning on behalf of the 750,000 members of the Disabled American Veterans to express our views on H.R. 1443.

I will be very brief. The DAV does support the 1-year extension proposed by H.R. 1443. We believe there remains a substantial number of veterans who continue to utilize the storefronts and contracting counseling services. While we believe the program is necessary and will be utilized well beyond the expiration proposed for 1985 in the bill, we also feel the VA should embark on a program to include such services within the VA for other Government facilities and to begin bringing the program into the mainstream of traditional VA health care programs.

By doing so, we believe the VA would be better prepared to deal with the many questions and concerns you wish addressed by the proposed study in H.R. 1443.

That concludes my remarks, Mr. Chairman. I am pleased to respond to any questions you may have. Again, thank you for letting us appear today.

[The prepared statement of Mr. Edmiston appears at p. 177.]

Mr. EDGAR. Thank you for the brevity of your statement at this time.

The DAV, in my opinion, should be congratulated because your organization had a project called the Forgotten Warrior project long before the Veterans' Administration or the Congress specifically addressed the need of looking for and trying to help Vietnam veterans. You led the way on the issue and I would like to congratulate you for that.

From this standpoint, would you think, given the experience that the DAV has had, that there is a continuing need to continue these storefront counseling centers to reach out and find Vietnam era veterans?

Mr. EDMISTON. Most definitely, Mr. Chairman. We feel there is a need to continue the program, but as I pointed out in my testimony, we believe the VA should at this point in history start programing to phase that into the existing system, as we did with our own program.

Mr. EDGAR. Thank you. I have no further questions.

Are there additional questions?

Mr. CHRISTOPHER H. SMITH. I have one question, Mr. Chairman.

Mr. EDGAR. The gentleman from New Jersey is recognized.

Mr. CHRISTOPHER H. SMITH. First of all I want to thank you for your statement and your brevity. Having read the statement, I just have one question.

You mentioned about the fee service mistake or whatever in Denver, Colo. Is that the only problem that you know of like that, where the vet center was close to where the fee service award was made?

Mr. EDMISTON. Yes, it is. At this point in time, that is the only one we have been made aware of.

Mr. CHRISTOPHER H. SMITH. I thank you.

Mr. Edgar. Thank you very much. I appreciate your statement.

Mr. Philip Mayo, special assistant, national legislative service, Veterans of Foreign Wars, is our next witness.

Mr. Bilirakis. Mr. Chairman, I assume that the DAV will respond to my question?

Mr. Edgar. Yes. We are going to ask each of the organizations to respond.

Mr. Mayo, your full statement will be made a part of the record, without objection. We invite you to summarize where possible.

Mr. Mayo. I would be happy to, Mr. Chairman.

STATEMENT OF PHILIP MAYO, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. Mayo. One of the gentlemen earlier asked what made the situation in Vietnam a little bit different than other wars. The situation I think is different because the warrior has borne the personification of the problems of the war rather than the war itself. I think that has come out quite amply today.

We think the staff in the vet centers are, so to speak, tuned in to Vietnam veterans. We are aware and agree that there are attitudinal problems in the VA and other places that need to be overcome. Consequently, we believe that the research that is addressed in the bill before the committee today is needed to get at the heart of what should be done to assist Vietnam veterans.

We feel particularly that this is true because we can see substance abuse, with alcohol and drugs, increasing among this group and it is a cause of great concern. We believe there is a connection between stress and substance abuse. This effort, we believe, requires a greater physical and human resources commitment on the part of the VA and other agencies to solve these problems.

What we are looking for is not so much a bigger bureaucracy than we already have; it is more a sympathetic and innovative application of the resources available in the VA and other Government agencies that would contribute to solving the problems that Vietnam veterans have.

I am speaking in terms, more specifically, like the Department of Labor and the SBA. We have heard testimony on earlier occasions about their programs to assist veterans. The DVOP's currently assist the vet centers and we recommend that the LVER's, local veterans representatives, and representatives of the SBA as well be utilized to assist veterans.

That completes my summary. Again, I appreciate the time the committee has taken to hear our views.

[The prepared statement of Mr. Mayo appears at p. 182.]

Mr. Edgar. Thank you very much. We invite you to respond to Mr. Bilirakis' question.

Mr. Mayo. I can do it now.

Our posts have been used in many cases for rap sessions all over the country. This information has come in to us and we have assisted in having SBA meetings in our posts as well.

We have service officers in every State and we have asked those personnel to go to the vet centers and help with claims and in any way they can to coordinate efforts to help Vietnam veterans.

We are also in the process of revising our Service Officers Guide, which we intend to provide every vet center with. We, as well, provide it to the Congress and all the officers of the Congress, and we have received back very favorable responses from the Congress on how it cuts through the redtape as far as dealing with claims. We are active in the BVA and regional offices in claims activity in support of Vietnam veterans. During the Vietnam Veterans Salute, I had many Vietnam veterans come to me and say that if it wasn't for the VFW and our service officers, they would be out in a field somewhere. That is the way I would respond to your question at the moment.

Mr. EDGAR. Thank you very much. I have no further questions. The gentleman from New Jersey.

Mr. CHRISTOPHER H. SMITH. Thank you, Mr. Chairman.

Mr. Mayo, first of all I want to commend the VFW for its very, very strong commitment to the Vietnam veteran. You have spoken out very strongly on behalf of the agent orange situation as well as on the readjustment counseling centers. You were one of the first and I think you are to be commended for it.

On page 3 of your testimony you referred to the waiting lists for psychological treatment, and indicate the Vietnam veterans are not receiving the treatment that they desperately need, thereby forcing vet centers to deal with what otherwise would have been an inpatient situation.

Could you elaborate on that and perhaps give us an idea so that this committee can get a handle on how many are waiting and what is the degree of——

Mr. MAYO. I wish I could give you a number. I can't. I think this problem has been brought out very clearly in the testimony of other witnesses this morning. There is simply not enough capacity in facilities available for the length of time that is needed to provide the care that is needed.

Mr. CHRISTOPHER H. SMITH. I guess the more narrow question is we know that the need is there and we're not really adequately addressing it, whether it be inpatient or outpatient. But your testimony puts an emphasis on the inpatient, the fact that we do not have enough beds.

Mr. MAYO. That is correct. I say further along in the statement that greater human and physical resources are needed to meet the problem and that is what needs to be done.

Mr. CHRISTOPHER H. SMITH. If the VFW does have any relevant data on that that would help this committee coming to a conclusion as to what is needed, I would certainly ask for it and, if it is provided, ask that it be included in the record.

Mr. EDGAR. Without objection, we would request that information.

Are there additional questions? Thank you very much.

Mr. MAYO. You're quite welcome, Mr. Chairman.

Mr. EDGAR. The witness receiving the honor, a plaque and an award for being the last witness, is Mr. John Terzano, the national legislative director of Vietnam Veterans of America.

John, we appreciate your being last and we will present you with this great plaque and tell you that on this date in history you have become the winner of that specific award.

Your full statement will be made part of the record, without objection, and we ask you to proceed as you see fit.

STATEMENT OF JOHN F. TERZANO, NATIONAL LEGISLATIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

Mr. **Terzano**. Thank you, Mr. Chairman.

You know, most people, when they come here to testify, prefer to be the lead-off witness. In reality, I prefer to be last for the simple reason it allows me to take in the proceedings and to address some of my comments to what has been said before.

There is one thing that I want to address that Dr. Brown mentioned with respect to money, because as far as I'm concerned, money is the bottom line here.

He said that they are going to have approximately $3 million left over from the contract-for-fees money and that that money probably will be used to fund the research. But he said they would have to come back in front of this committee to get that type of authorization.

I seem to recall, Mr. Chairman, that back in 1981 Dr. Custis took the whole contract-for-fees money and paid the utility bills of the VA with it. So I think they have that authority to transfer the money right away.

But what frustrates me so much is that we are talking about an insignificant amount of money for a program that has done an exceptional job. The bottom line—and I guess the best analogy I can use for this is that we are treating a sucking chest wound with a band aid. That is what has happened with the vet center program.

We have talked about the need for research and we have talked about the need for an extension—I might add, in our written statement VVA called for a 3-year extension—even though I personally feel that that's probably not long enough, I do feel it is a reasonable extension that Congress could accept. But nobody has talked about expansion and enhancement of this program.

Every vet center out there has four people in it. Fifty percent of the team leaders' time is spent on administrative work, which leaves three counselors to do a yeoman's job out there. We don't have enough centers. We don't have enough satellites, and we don't have enough employees for this program.

I think what this committee has to do, plain and simple, is to bite the bullet, appropriate extra money to do the research and to expand and enhance this program. This thing has gone on too long on nickel and dime moneys as far as I'm concerned.

In answer to Congressman Bilirakis' request, part of the problem with outreach is that because the vet centers are understaffed, and they don't have sufficient funds, the VA itself isn't doing outreach. They can't do Outreach. The 80,000 new clients that they expect to come in this year are walk-in clients. There is a need to do Outreach, to go out into the rural areas, into the hills, to bring these people into the program. But you are not going to do it with $21 million and with the present staffing level.

Mr. Chairman, The vet center program has proven to be cost effective. That program, when compared to any other program within the VA, is the most cost-effective program the VA offers. I think it is time to move this thing forward, and I think it is time to appropriate the right amount of money and staff so we can get the job done.

Thank you.

[The prepared statement of Mr. Terzano appears at p. 185.]

Mr. EDGAR. Thank you very much. Your testimony is much appreciated in terms of expanding our vision and our horizon. I think after listening to the need and the value of the program, I think you make a wise point in terms of nickel and diming the program with limited funds when it is such a small amount of money for such a large investment. I appreciate your statement and wanted to underscore that particular comment.

I have no additional questions to ask. The gentleman from New Jersey?

Mr. CHRISTOPHER H. SMITH. Thank you, Mr. Chairman.

Mr. Terzano, I want to commend you on your fine statement. I have read your written remarks and they go very much to the point of what we are speaking to. I have just a few questions.

You note that approximately 29,000 clients were seen in 1980 and that number will jump to some 80,000 in 1983. Then later down you note that some 700,000 will be seen, but you don't give any specifics as to over what period of time.

What I am asking is, what do you project the growth of the number of vets who will utilize the Centers over 1984, 1985, 1986, 1987, as we are talking of—Mr. Evans is going to be introducing legislation today to extend it for 3 years. Is 3 years a magic number? I know you indicated that perhaps it should be longer. If we have the necessary data to show a growth, perhaps we could extend it to 4 or 5 years. If you could provide that for us, I would appreciate it.

Mr. TERZANO. That figure, Mr. Smith, is a figure that a lot of the researchers have come up with, that by the end of 1984, the beginning of 1985, that upwards of 500,000 to 700,000 people will manifest some symptoms of PTSD.

We haven't even begun to peak yet. Of that, there is no doubt. If we are looking down the road in 1985 starting to phase this program down, we're going to be running into some serious problems.

We have got to take this program out of the political picture here and let it operate the way it should operate, as an autonomous storefront operation out there in the field and doing its job.

Mr. CHRISTOPHER H. SMITH. How many new vet centers do you think would be needed in addition to the 136?

Mr. TERZANO. I would suspect that probably between 10 and 12 new centers with an additional maybe 200 full-time equivalents, whatever they're——

Mr. CHRISTOPHER H. SMITH. Do you have any identified geographic areas as to where they should be placed?

Mr. TERZANO. I don't, but I would expect that Dr. Blank would have that. They have a better handle on the demographics.

Mr CHRISTOPHER H. SMITH. Is the 10 or so based on what the VA has cited as the need, or do you have some independent analysis?

Mr. TERZANO. We haven't done an in-depth analysis ourselves. But I would suspect that that would take care of it, yes.

Mr. CHRISTOPHER H. SMITH. Because I know from my own State's point of view we recently had the Trenton Vet Center opened and it has been servicing a great number of vets who were in need of that service. In south Jersey we have a very real need and the distance of traveling to anywhere from Cape May in Atlantic County to Trenton is too prohibitive, so that would be a primary site for a new Center.

Mr. Chairman, I just want to suggest that we look into—and one thing I am going to be looking into—is to how many new Centers would be needed to meet the need. As you say, every year the number of diagnosed cases may increase and we have got to be prepared for that.

Thank you for your fine testimony.

Mr. EDGAR. If our colleague from Florida were here, Mr. Mica, all of them would be put in Florida. [Laughter.]

Mr. BILIRAKIS. One of your colleagues from Florida is here, but that would be unfair.

I would just like to say, sir, to echo your remarks, the testimony was excellent. We appreciate your taking the time and trouble to come such distances as some of you have. We appreciate your tolerance and patience with us. The coming and going and running back and forth, for the most part, cannot be helped. We appreciate your tolerance there.

Thank you, and thank you, Mr. Chairman.

Mr. EDGAR. To the point of the number of centers, the gentleman from New Jersey is right in raising the question of what is enough and what are the areas.

In cur last hearing we looked at the medical regions that are laid out, and some of them are pretty broad and pretty vast. We have to be mobile enough to think of not only setting up the vet centers but what mobile centers need to be established, particularly for rural communities that may need some outreach and some help.

Your testimony was outstanding, and all of those who testified today made a real contribution to this particular issue. We do plan to mark up legislation in the very near future before the May 15 deadline. There will be some continuing discussions and questions back and forth.

I would also remind my colleagues that we intend to have the first of our field hearings in late April in the Pittsburgh-Erie-Butler, Pa., area, which will be the first of six field hearings going out throughout the country, including Florida, California, Wisconsin, Minnesota and San Francisco. But we look forward to going across the country and looking at not only the fixed assets of the veterans' health care system but also the storefront centers that are represented by the legislation we talked about today.

This hearing stands adjourned. We will reconvene when possible.

[Whereupon, at 1:30 p.m., the subcommittee was adjourned.]

APPENDIX

I

98TH CONGRESS
1ST SESSION

H. R. 1443

To amend title 38, United States Code, to extend by one year the period during which Vietnam-era veterans may request psychological readjustment counseling from the Veterans' Administration and to direct the Administrator of Veterans' Affairs to carry out a comprehensive study of the prevalence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 15, 1983

Mr. EDGAR introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to extend by one year the period during which Vietnam-era veterans may request psychological readjustment counseling from the Veterans' Administration and to direct the Administrator of Veterans' Affairs to carry out a comprehensive study of the prevalence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 612A of title 38, United States Code, is amended—

(1) by striking out "September 30, 1984" in subsection (a) and inserting in lieu thereof "September 30, 1985"; and

(2) by striking out "September 30, 1984", "October 1, 1984", and "April 1, 1984" in subsection (g) and inserting in lieu thereof "September 30, 1985", "October 1, 1985", and "September 30, 1984", respectively.

SEC. 2. (a) The Administrator of Veterans' Affairs shall conduct a comprehensive study of the readjustment of Vietnam-era veterans to civilian life. The study shall include a nationwide survey of the prevalence and incidence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans and a survey of the health status of the Vietnam-era veteran population in relation to that of the general population.

(b) Each portion of the study shall be done with a sample of sufficient size to support statistically valid projections about the entire population of Vietnam-era veterans and shall include separate statistical findings for veterans with service-connected disabilities, veterans who served in the Vietnam theater of operations during the Vietnam era, and women veterans

(c)(1) The readjustment portion of the study shall include a psychological evaluation of the population of Vietnam-era veterans, an economic evaluation of such population in terms of income level and employment achievement and satisfaction, and a sociological evaluation of such population, including an evaluation of the extent and incidence of the long-term effect of post-traumatic stress disorders among Vietnam-era veterans on the families of such veterans (and on persons in other social relationships with such veterans). The survey shall also be designed to yield information to aid in determining whether there is a correlation between the occurrence of post-traumatic stress disorders in such veterans and alcohol abuse or drug abuse among such veterans and whether there is a correlation between the occurrence of post-traumatic stress disorders in such veterans and the incarceration of such veterans in Federal, State, or local penal institutions.

(2) The health status portion of the study shall survey (through the use of established health inventory methodologies) the current and past health status of the population of Vietnam-era veterans and shall specifically be designed to determine the extent of and relationship (if any) between the occurrence of post-traumatic stress and related psychological disorders within such population and the occurrence of psychobiological or medical disorders within such population. The survey shall also include a determination of the extent of the use by Vietnam-era veterans of Veterans' Administration

health care facilities. Such determination shall be categorized by type of facility, type of care provided, and (to the extent practicable) user satisfaction with the care provided.

(d) Not later than December 31, 1984, the Administrator shall submit to Congress a report on the study conducted under this section. The report shall include detailed findings and conclusions and a description of methodologies used and statistical assumptions made. All findings and conclusions shall be stated in terms of the population of Vietnam-era veterans in general and of the portion of that population consisting of veterans with service-connected disabilities, the portion consisting of veterans who served in the Vietnam theater of operations during the Vietnam era, and the portion consisting of women veterans.

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I

98TH CONGRESS
1ST SESSION

H. R. 2213

To amend title 38, United States Code, to extend by two years the period during which Vietnam-era veterans may request psychological readjustment counseling from the Veterans' Administration and to direct the Administrator of Veterans' Affairs to carry out a comprehensive study of the prevalence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 21, 1983

Mr. MICA introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to extend by two years the period during which Vietnam-era veterans may request psychological readjustment counseling from the Veterans' Administration and to direct the Administrator of Veterans' Affairs to carry out a comprehensive study of the prevalence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 612A of title 38, United States Code, is amended—

(1) by striking out "September 30, 1984" in subsection (a) and inserting in lieu thereof "September 30, 1986"; and

(2) by striking out "September 30, 1984", "October 1, 1984", and "April 1, 1984" in subsection (g) and inserting in lieu thereof "September 30, 1986", "October 1, 1986", and "September 30, 1985", respectively.

SEC. 2. (a) The Administrator of Veterans' Affairs shall conduct a comprehensive study of the readjustment of Vietnam-era veterans to civilian life. The study shall include a nationwide survey of the prevalence and incidence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans and a survey of the health status of the Vietnam-era veteran population in relation to that of the general population.

(b) Each portion of the study shall be done with a sample of sufficient size to support statistically valid projections about the entire population of Vietnam-era veterans and shall include separate statistical findings for veterans with service-connected disabilities, veterans who served in the Vietnam theater of operations during the Vietnam era, and women veterans.

(c)(1) The readjustment portion of the study shall include a psychological evaluation of the population of Vietnam-era veterans, an economic evaluation of such population in terms of income level and employment achievement and satisfaction, and a sociological evaluation of such population, including an evaluation of the extent and incidence of the long-term effect of post-traumatic stress disorders among Vietnam-era veterans on the families of such veterans (and on persons in other social relationships with such veterans). The survey shall also be designed to yield information to aid in determining whether there is a correlation between the occurrence of post-traumatic stress disorders in such veterans and alcohol abuse or drug abuse among such veterans and whether there is a correlation between the occurrence of post-traumatic stress disorders in such veterans and the incarceration of such veterans in Federal, State, or local penal institutions.

(2) The health status portion of the study shall survey (through the use of established health inventory methodologies) the current and past health status of the population of Vietnam-era veterans and shall specifically be designed to determine the extent of and relationship (if any) between the occurrence of post-traumatic stress and related psychological disorders within such population and the occurrence of psychobiological or medical disorders within such population. The survey shall also include a determination of the extent of the use by Vietnam-era veterans of Veterans' Administration

health care facilities. Such determination shall be categorized by type of facility, type of care provided, and (to the extent practicable) user satisfaction with the care provided.

(d) Not later than December 31, 1984, the Administrator shall submit to Congress a report on the study conducted under this section. The report shall include detailed findings and conclusions and a description of methodologies used and statistical assumptions made. All findings and conclusions shall be stated in terms of the population of Vietnam-era veterans in general and of the portion of that population consisting of veterans with service-connected disabilities, the portion consisting of veterans who served in the Vietnam theater of operations during the Vietnam era, and the portion consisting of women veterans.

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STATEMENT OF

LAWRENCE C. KOLB, M.D.
DISTINGUISHED PHYSICIAN IN PSYCHIATRY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

March 24, 1983

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to discuss the Veterans Administration's Psychological Readjustment Counseling Program.

During the past five years and in my present position I have been actively involved in the diagnosis and treatment of combat veterans of the Southeast Asian Conflict who suffer the Chronic and Delayed forms of the Post Traumatic Stress Disorder of War. Most of this work has been carried out at the Albany VA Medical Center. I have also consulted at and instructed the staffs of some 30 other medical centers on this subject, was instrumental in development of the Capital District Veterans Outreach Center and attend there as a medical-psychiatric consultant twice monthly. I have not been working with the Vietnam-era non-combat veterans.

In the course of this work I have personally examined about 140 men with this condition and have been involved in the treatment of about 50% of these men either in individual or group work or through prescription of pharmaceuticals. As the result of this work, the hospital which had not services for this condition before my attachment there offers now weekly three group sessions for men so suffering and one group treatment session for wives and girlfriends. A new psychophysiological laboratory has been established for diagnostic screening, a research project is underway in which my colleagues and I are engaged in treatment of certain of the fixed symptoms of the condition through prescription of well known and established adrenergic blocking agents.

Let me state that new patients even now continue to appear both in the hospital and in the local outreach center. The latter offers both direct and contract services through a 20 county area in northern New York State and Western Massachusetts. The load of patients in continuing care has expanded each year and continues to grow both in the hospital and at the outreach center.

As mentioned my experience is largely hospital based. My patients have been found on medical and surgical services as well as on the various in and outpatient psychiatric units including the alcohol rehabilitation unit. The majority of the men admitted to hospital inpatient services with this condition are socially more seriously maladapted than those in outpatient services or seen at the outreach center. Many have suffered physical wounding during the conflict but not of a major mutilating variety. About 5% have had major dissociative states(flashbacks as they are called popularly) in which they violently reenact some combat scenes in public. Often such threatening behavior has led to their arrest and detention. Fortunately none of the men seen by me have brought serious harm to others. Many have been unable to hold jobs, have been divorced or have isolated themselves socially or through alcohol abuse. We have seen only two with hard drug habits.

I came to this work from experience during World War II of treating men of all services in both the Pacific and Atlanta theatres who had the acute symptoms of the condition. We then used very successfully the injection of barbiturates (so-called narcosynthesis) to relieve the seriously impairing symptoms of profound stupor, confusional states, paralysis and various tics and agitation. Later on between 1950 and 1975 in civilian life both at the Mayo Clinic and at the Columbia-Presbyterian Medical Center in New York I saw and treated others who had acutely developed the condition as the result of such major catastrophies of civilian life as auto accidents and industrial explosions. I have consulted on others who had the chronic symptoms as the result of concentration camp experiences or prisoner of war experiences. As for the latter I saw many of the evacuees from the Japanese Cabanatuan camp in the Phillipines who had the condition. We have known in psychiatry for 100 years that life threatening civilian catastrophies such as volcanic explosions, hurricanes, floods, mine explosions and cave ins, major fires may produce this condition. It has been variously labelled over the years as traumatic neurosis, fright neurosis, shell shock, combat fatigue and disordered action of the heart and now in this country Post Traumatic Stress.

We have statistics that the frequency of its occurrence directly relates to the occurrence of death and wounding in combat units. We do not have good figures on the numbers of men who fail to recover from the acute phase and go on to develop the chronic and delayed forms. There exists in my opinion only one outstanding study of the chronic form - that carried out on World War I veterans just prior to World War II by Kardiner at a VA Hospital.

Kardiner suggested that the hospitalized men with the chronic condition which he saw suffered an illness unlike the civilian neurosis which he called a physioneurosis.

My own work with the hospitalized men severely disturbed with major flashbacks and panic attacks seems to confirm his opinion of the existence of a persisting physiological abnormality in some men that goes beyond psychological impairment. We have found in 14 of 18 men that under light barbiturate narcosis when exposed to a short train of meaningful combat sounds (30 seconds) they immediately regress in time to a combat scene and act out that scene. Furthermore in contrast to same aged non-veterans when exposed in the fully conscious state they immediately respond by high rises in systolic blood pressure, heart rate and muscle tension as recorded on a polygraph. These studies indicate to me a lowering of their perceptual barrier to threatening stimuli reminiscent of combat, inappropriate physical arousal, incapacity to maintain attention, tendency to neurologically determined explosive behavioral responses. They also show that these men are at high risk for psychological dissociation when under the influence of any mind altering drug - alcohol or otherwise or when exposed to anesthesia as during a surgical procedure.

We believe the physiological abnormalities are due to excessive discharge of adrenergic substances within the brain. I am of the opinion that the physiological test just described may prove to be of diagnostic value in terms of severity and chronicity of Post Traumatic Stress Disorder. Furthermore it may offer a monitoring device to test the efficacy of various forms of treatment.

For the past six months my colleagues and I have treated men demonstrating such symptoms with adrenergic blocking agents - such as inderal and clonidine - widely used in the treatment of hypertension. We are impressed with the clinical improvement many have experienced. We do not believe such medical treatment alone can alleviate the total clinical picture of chronic conditions as many of the men suffer from secondary anxiety and depression related not only to untreated and unresolved conflicts over the actions they were ordered to undertake in Vietnam but the trauma inflicted upon them by the failures in debriefing and the social mistreatment imposed upon them on return to this country.

In my opinion there is a need to continue to strengthen the treatment facilities for these men both in the medical centers and the outreach centers, to improve the working relationship between the two and to support vigorously new research efforts related especially to the chronic and delayed forms of Post Traumatic Stress Disorder.

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the committee may have.

[Reprinted from Psychiatric Annals]

The Conditioned Emotional Response: A Sub-Class of the Chronic and Delayed Post-Traumatic Strees Disorder

(By Lawrence C. Kolb, M.D. and Louis R. Mutalipassi, PH. D.)

This article introduces data drawn fromn clinical experiences which support the contention that the nuclear pathology of certain chronic and delayed post-traumatic stress disorders of war rests in the persistence of a conditioned emotional response. This concept suggests the need for a re-examination of the psychobiological concomitants of the state, a re-evaluation of current diagnostic and therapeutic processes and development of alternative treatment methodologies.

This data evolved from observations of immediate therapeutic response of narcosynthetic abreaction in Vietnam combat veterans who reported symptoms of post-traumatic stress disorder either chronic or delayed forms as defined in DSM-III.[1] During World War II and later in recognized cases resulting from catastrophes occurring in civilian life, this technique was utilized extensively to bring about relief from seriously imparing major behavioral symptoms for those seen with the condition in the acute state.[2,3]

Working within the framework of a pain clinic, a general hospital psychiatric consultation service and an inpatient psychiatric service in a Veterans Administration Hospital, a number of hitherto unrecognized cases of the chronic and delayed post-traumatic stress disorder were discovered. These cases presented with continuing behavioral abnormalities exhibited in explosive episodes of rage, dissociative states with acting out of combat defensiveness (flashbacks), repetitive panic (anixety) attacks and abonormal pain-complaining behavior. All the patients had demonstrated continuing difficulties in social adaptation since their discharge from military service following combat experience in Vietnam.

THE CONCEPT

In 18 of the 94 cases, the clinical history and examination suggested a persistent intensely repressed effect unalleviated by previous therapeutic approaches. In these cases a decision was made to initiate narcosynthesis. The authors recognized that abreaction, if obtainable, was unlikely to provide more than an immediate alleviation of tension. To achieve enduring benefit, therapeutic "working through" of material produced during the abreactive state would be necessary through either group or individual treatments.

The histories from some of the patients who were first seen suggested persistence of startle response to loud sounds. Considering the likelihood that the abreactive material would be forgotten in whole or in part following recovery of full consciousness from the subnarcotic administration of a barbiturate, the traditional technique of narcosynthesis was modified as follows:

The abreactive response was stimulated by exposure to an auditory tape recording consisting of a sequence of 30 seconds of musical sounds, 30 seconds of silence and 30 seconds of sounds typical of the Vietnam combat experience with avoidance of verbal suggestion of time and place regression to the combat site.

An audio-visual television recording was made of the abreactive response.

A review of the audio-visual recording of the abreactive behavior was completed with the patient in the presence of the therapist after recovery of consciousness.

The patient was offered the opportunity of an additional review of the recording alone or with others whom he suggested. In nine of the 18 treated cases, patients requested reviews with their wives and two reviewed their responses with patients. On one occasion a subject suggested a review with all the members of a combat veterans "rap" group.

The modifications of the stimulus to a standard audible sound rather than use of verbal suggestion was introduced to examine the potential that much of the episodic symptomatology of the severe chronic combat-induced stress disorders might be due to a conditioned emotional response. The second modification, the audio-television taping, was based on the hope of using the recorded data for therapeutic confrontation later in the pre-arranged continued treatment.

In Kardiner's[4] studies of the chronic post-traumatic war neurosis following World War I, the following were identified: (1) irritability and startle pattern as among the five constant features of the post-traumatic states induced by combat experience; (2) fixation on the trauma (an altered concept of self and the outer world); (3) atypical dream life; (4) proclivity to explosive aggressive reactions; and (5) contraction of the general level of functioning including intellectual function.

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[1] Footnotes at end of the article.

Kardiner emphasized "irritability" as present in every case of traumatic neurosis and related this behaviorial symptom to exposure to auditory stimuli which induced a startle reflex pattern followed by fright, explosive violence or generalized tremor. Kardiner also noted that sensitivity may exist to other stimuli (light, smell or special stimuli such as snow, rain, etc.). The patients' significant relationship to arousal or irritability was determined by their association to the circumstances of the initial trauma. The sensitivity of such stimuli was conceived as "the character of a conditioned reflex"—not learned over time but automatically recurring. He proposed that there existed a central physioneurosis related to impairment of those personality functions which assist adaptation of the individual to the real external world, in contrast to the ordinary neurosis where the problem is adaptation to inner world representations of humanity and society. Shortly thereafter, others who worked with the acute cases treated in the course of World War II also referred to the startle response and other phobic responses as due to "conditioning".[5,6]

Kardiner pointed out that psychologically traumatic experiences might precipitate any personality disorder but that no matter the features of that disorder the cardinal symptoms of the traumatic war neurosis co-exist with and are always present in the clinical picture of any other pre- or co-existing syndrome.

THE PATIENTS

Over a three-year period, 94 combat veterans of Vietnam were identified from a large number of patients seen in consultation in the various services of the Veterans Administration Medical Center in Albany, New York. All were examined medically and psychiatrically. Other consultations were requested as indicated.

Each of the veterans completed the Minnesota Multiphasic Personality Inventory and the Center for Policy Research 13 Point Combat Scale.[5] Eleven later received a physiologic assessment in the Stress Laboratory of the State University of New York at Albany.[5]

A group of 18 men were 29 to 34 years of age when treated by narcosynthesis (17 to 21 years of age when they entered the military). Eight of these men were married; nine were divorced (three were living with girlfriends) and one was single. One had some college education, the remainder had completed high school or were in high school at the time of induction into the military. Employment varied in that six held regular jobs, three held occasional jobs and nine were unemployed.

History of mental illness in parents or sibling existed in two instances. One man had two epileptic brothers. One was adopted and another lost his parent at age seven and was reared by a grandmother. A third was placed in a foster home from age six to 14. None of the patients had been identified as psychiatrically ill prior to the period of military service. The developmental histories were devoid of indicators of pre-existing personality disturbance except for two who had difficulties with school authorities or the law prior to entering the military.

Ten patients were wounded in Vietnam but only one had a persistent visible deformity with limitation of motion. Ten reported loss of a close "buddy" during combat. Sixty percent scored in the high range on the combat scale.[6]

METHODOLOGY

Sodium pentothal was administered intravenously by the drip method by a member of the anesthesiology staff in all but the first three cases where sodium amytal was administered intravenously by syringe. The total dosage injected varied from 250 mg to 500 mg of the agent used for each individual. The patient's physiological status was monitored in 16 instances during narcosynthesis by means of continuous recording of electroencephalogram, electrocardiogram and respiratory rate.

Patients were advised beforehand that they would receive an intravenous injection of a barbiturate and that this treatment might reduce their persistent state of tension and anxiety. They were told that when it was apparent they were in a clinical state where there was beginning impairment of consciousness (judged by slurring of speech and impaired ability to count backwards), they would be exposed to a soundtrack consisting of musical and combat sound. They were informed they might re-enact their battle experiences and then fall into a light sleep. Later, after regaining consciousness, they would review the behavioral observations made by the treatment team. They might then wish to comment more fully with regard to their experiences and consequences upon their present living situation. All patients were informed of potential adverse effects from administration of the drug and the measures to be taken if any evidence of physiological or psychological distress developed.

All patients voluntarily signed a consent form for intravenous administration of the drugs and for audiotelevision recording of their behavioral response. The consent was reviewed again with each patient to determine if he wished to withdraw the privilege to show the recording to selected audiences. None did so.

RESULTS

Of the 18 Vietnam combat veterans exposed to a 30-second segment of combat sounds while under light (arousable) barbiturate narcosis, 14 immediately responded and abreacted emotionally to a traumatic war experience when stimulated with the 30-second combat soundtrack with time regression. The initial noted behavioral responses may be classified as alerting, fighting, fleeing or crying. There were other affective displays associated with verbal reliving of the traumatic scene. As consciousness clarified, some men erupted into further affective display while explaining their conflicts consequent to the experiences of loss of buddies. The affects evident during the abreaction were fear, rage, indignation, sadness and guilt.

Of the four who failed to abreact to the combat stimulus, two were previously chronic alcoholics. These men required large doses of pentothal before evidence of cognitive impairment occurred and then quickly became unarousable. The other two indicated that the sound sequences were not meaningful to them. One identified the soundtrack as World War II sounds and the other stated that he was not startled by sounds. No combat veteran responded with abreaction to the initial 30 seconds of non-combat-meaningful sounds (music). Two non-combat veterans exposed to the same stimuli while under narcosynthetic study for reasons other than treatment of a post-traumatic state did not respond to the combat sounds.

There was no evidence of abnormality in the electroencephalogram other than the presence of fast wave voltage secondary to the barbiturate administration. Cardiac rates remained unchanged. In some there were periods of increased respiratory rates.

Since the possibility existed that changes in various physiological systems may have occurred simultaneously with the observed emotional abreactions, but were obscured by the countereffects of the intravenously injected drugs, further exploration was made in collaboration with Professor E. Blanchard, T.P. Pallmeyer and R.J. Gerardi of the Stress Laboratory, State University of New York, Albany (unpublished data, 1982). Eleven combat veterans with the clinical symptomatology of the post-traumatic stress disorder of war were exposed to the same soundtrack played at different instensities in a fully conscious state, while physiological assessment of heart rate, blood pressure, frontal muscle activity, peripheral skin temperature and skin resistrance were monitored on a Grass Model 7D polygraph. Similar exposure and physiological assessment was made of 11 post-doctoral university students of the same age range. Both groups were also stressed with a mental arithmetic problem. The results of the analysis of the physiological data show that both groups responded similarly when presented with the arithmetic stressor. However, when combat sounds were presented the veterans all displayed significant increases in heart rate, systolic blood pressure and forehead muscle activity whereas the control subjects exhibited no significant changes. One exception was a veteran then on haldol who also stated that the sounds were unrealistic. All veterans were differentiatingly responsive to combat sounds over the musical passages and on a baseline level.

Treatment experience completed for the series of men exposed to narcosynthesis is another important factor. In the immediate period following narcosynthesis none of the men recalled their abreactive experience or behavior. During review of the televised abreactive response with the therapist, an impression was gained of immediate increase in self-acceptance and esteem. Several days later many reported affects of sadness or depression. All veterans who were married or living with a girlfriend requested that the tape be shown to their consort, and consequently they reported a greater understanding of and compassion of their erratic behavior by wives or girlfriends. "Working through" was attempted by engaging those abreacted in group therapy supplemented in some cases with individual therapy and pharmacotherapy. There was no recurrence of trance-like dissociative states or panic attacks in any treated subjects. Depressive affect was diminished. On the other hand, startle and sleep disturbances in terms of sleep phobia and repetitive combat nightmares continued.

DISCUSSION

These observations demonstrate the propensity of a group of Vietnam combat veterans with the chronic or delayed forms of the post-traumatic stress disorder of war to: (1) cognitively dissociate in a drug altered state of consciousness on exposure to a combat sound stimulus with time regression and acting out of a single or several psychologically traumatic incidents; and (2) develop immediate physiological hyperactivity in the cardiovascular and neuromuscular systems. The former response was not present in four men who nevertheless had the clinical symptoms of the stress disorder.

We posit the existence in the responding group of men of an abnormal potential for arousal of the emotion of fright with all its physiological concomitants when exposed to appropriate stimulation.

We suggest the existence of an ongoing perceptual motor abnormality with regressive impairment of perceptual discrimination and fixation through emotional conditioning to a primitive startle-arousal patten. The physiologic overactivity probably is mediated through central adrenergic pathways.

The perceptual impairment is evident clinically. Four veterans were precipitated into dissociative states or acute panic attacks through re-exposure to situations which simulated combat. One veteran did so after joining a National Guard Unit and suddenly awakening in his trench during nighttime maneuvers. Another, who was a state policeman, panicked when placed in special units prepared to carry out violent attacks if required. Perceptual discrimination, furthermore, is impaired further when consciousness is altered through use of alcohol or other mind altering drugs, in light sleep, hypnotic or narcosynthetic states.

Our work confirms the observations of Dodds and Wilson who compared studies of World War II veterans with chronic posttraumatic stress disorder of war.[7] They compared the psychophysiological responsivity of two groups of World War II veterans with the posttraumatic stress disorder combat veteran's group (13 men adjudged socially compensated and eight men adjudged socially decompensated some ten years after the war experience) with a group of ten non-combatant university students. They monitored the electroencephalogram and pulse and respiratory rates following eight minutes of auditory stimulation of combat sounds, and during the last four minutes of the recording, single light flashes from a photic stimulator were added. A five to seven minute baseline period of recording preceded the stimulation. Increases in pulse and respiratory rate as well as a decrease in alpha rhythm occurred in the vast majority of the combat veterans but not in the control group. Dodds and Wilson concluded that there existed "remarkable similarity of the behavioral and physiological responses of the war neuroses to those produced experimentally in animals through conditioning." They suggested that sounds and sights simulating those of combat serve as conditioned stimuli to induce the self preservation emotional responses of fight, flight or paralysis which become the conditioned response.

The unconditional stimulus and response are contained in the innate startle response of infancy. Startle response to loud sounds has been recognized as a behavioral manifestation of fear since the earliest studies of the conditioning of infants.

Strauss described in detail an identifiable motor response discovered in infants as well as adults produced immediately following exposure to loud sounds.[8] Landis' study of the startle pattern clearly describes the simple reflex pattern of startle to sounds.[9] He separated those behavioral aspects of the response associated with fear and noted that the startle reflex might be conditioned following the first presentation of unconditioned and conditioned stimuli in some subjects who "did not enjoy the experience." Landis reported differing affective associations to sound startle such as curiosity, fear, annoyance (rage) and "overflow." These secondary conditioned responses were differentiated by Strauss as falling into behavior categories of defense, flight and spying.

Children show a preponderance of fear and flight behavior on exposure to sharp loud sounds. With aging the frequency of development of secondary conditioned responses diminishes. What has been denoted as the startle response in the clinical phenomenology of the posttraumatic states would seem to be the secondary learned conditioned responses to fear over and beyond the innate reflexive pattern of the infant.

Eysenck's recent revision of the learning theory model of the neuroses seems to apply to this group of men with chronic post-traumatic stress disorder:[10] Eysenck postulates that extinction fails to take place when the conditioned response contains emotions such as fear which takes on drive propensities which induce, after an incubation period (delay?) an enhancement of the neurotic process. He accords frustrative non-reward as the nocive stimulus in man and even suggests that the concept of learned helplessness may have relevance as the response to the stimulus.

In the chronic war induced stress disorder cases reported we perceive the operating stimuli for the continuing or delayed symptomatology to be both eruption of emotion on exposure to external fear inducing stimuli (sound or sight in the current social setting) and arousal of the conditioned emotional response through socially frustrating incidents and transactions.

But the total phenomenology of the post-traumatic stress disorders of war are beyond full explanation within the learning theory model. Freud recognized from his examination of the data that the phenomenology of the war neuroses might not be explained on the basis of his libido theory and that this condition and the social neuroses were related in that they each demonstrated the action of repression and the existence of conflict within the ego.[11] He intimated, however, that more resemblances might exist than those foreseen from the superficial studies of the acute cases studied in World War I. Thus, "the traumatic neuroses and war neuroses may proclaim too loudly the effects of mortal danger and may be silent or speak in muffled terms of the effects of frustration in love."[11]

Horowitz, avoided the affective components in his descriptions of the evolution of the cognitive processes built up by various personality types to defend against their never ceasing repetitive thoughts.[12] He does not bring us to conceptualize the drive forces which lead to the delayed or recurrent explosion of symptoms, which we regard as evidence of both weakness and fragility of the cognitive defensive structure so evident in the veterans reported upon here. These we postulate to rest in our cases in the persistence of the conditioned emotional responses.

Horowitz presents strong evidence that intensity and duration of stress are directly related to the precipitation of the chronc stress disorders over and above the possible predispositions through genetic, constitutional, developmental and physiological status of the potential sufferer.

In every sufferer of acute stress following a catastrophic exposure, a variety of aversive and behavioral expressions take place in an effort to escape the perceptual heightening of stimuli signaling threat. The memory traces recurrent in the cardinal symptoms of this condition are: the intrusive thoughts, repetitive dreams, irritability, explosive rage and the changed concept of self. Psychologically, suppression, repression and denial predominate as the defensive processes. From the behavioral standpoint, the aversive moves are evident in social withdrawal, the use of alcohol and other drugs. avoidance of all persons, places and dramatic representations which recall the catastrophic event and its attendant affects of fright, helplessness and rage.

During the aftermath of the catastrophic event the exposed individuals reflect upon and evaluate their personal actions and inactions in relation to their survival and the survival of others. It is this latter cognitive processing which induces the secondary emotional responses of shame and guilt wherein the individual judges both his own sense of relief in survival as well as his possible failure in preventing the survival of others. When the aversive defenses fail, as they often do, the irritability, attacks of rage, panic attacks or cognitive dissolution occur with acute dissociative episodes (flashbacks) in which the sufferer may fantasize or even re-enact the traumatic scene. The sufferer lives in constant dread of and expectation of recurrence of a catastrophe.

There are probably many individuals who develop acute post-traumatic stress disorders where cognitive processing protects and allows extinction of excessive emotional responsivity, and of the cardinal symptoms which subside over time. Over observations delineate the existence within the group of chronic and delayed post-traumatic stress disorders of a subgroup of individuals who suffer persistent driving through persistent conditioned emotional response.

This data, as well as that of Dobbs and Wilson,[7] support the Kardiner hypothesis of a basic physioneurosis existing within some men with the chronic post-traumatic disorder of war and suggest an enduring potential for pathophysiological arousal of self-preservative emotion in the face of stimuli signaling threat affect.

The delayed form of the condition represents no more than dramatic behavioral expression in individuals whose already overtaxed defensive structure fails in the face of increased frustration derivative of attempts to function socially.

From our histories the delayed eruptions have occurred most frequently in the face of anxiety aroused in transactions within the family or at work which induces recurrent and explosive rage, secondary regeneration of fear, anxiety, shame and guilt and eruption of the previously suppressed memories of the original major trauma. In the chronic and delayed forms, these men are both constrained to control their emotional instability as well as the conflict between yearing for intimacy with others and the fearful, possibly uncontrollable aggressivity toward others. Ultimately there are the agonies of the dread of or loss of still another person who is close.

If the above premises are verified further there are numerous implications for both diagnosis and treatment. Thus physiological assessment on exposure to combat sounds may be developed as a diagnostic indicator either of (1) the existence of a specific subgroup of the disorder in which there persists an abnormal emotional response (2) of a grade of severity of the disorder or (3) as a monitoring device to assess therapeutic intervention.

The varieties of psychotherapeutic approaches to combat veterans of Vietnam, as well as others with posttraumatic stress disorder provide some alleviation of secondary anxiety, guilt and shame. In the group described here it is unlikely that these procedures alone will eradicate the basic psychopatholgy—that is, the potential for excessive arousal due to the persistent defect in the emergency control system. The primary therapeutic focus would seem more appropriately focused on attenuation or suppression of the conditioned emotional response. This is currently being explored clinically through prescription of adrenergic blocking agents and through trial of imaginal desensitization.

REFERENCES

[1] *Diagnostic and Statistical Manual of Mental Disorders*, ed. 3. Washington, American Psychiatric Association, 1980.

[2] Grinker RR, Spiegel JJ: *Men Under Stress*, New York, McGraw-Hill Book Co., 1945.

[3] Shorvon HJ, Sargent L: Excitatory abreaction: With special reference to its mechanisms and the use of ether. *Journal of Mental Science* 1947; 90:709-732.

[4] Kardiner A: *The Traumatic Neuroses of War. Psychosomatic Medical Monograph.* New York, Paul Hoeber, 1941, pp 11-111.

[5] Gillispie RD: *Psychological Effects of War on Citizen and Soldier.* New York, WW Norton Co. Inc., 1942.

[6] Center for Policy Research Inc.: *Legacies of Vietnam: Comparative Adjustment of Veterans and Their Peers.* Government Printing Office, 1981.

[7] Dobbs D, Wilson WP: Observations on persistence of war neurosis. *Diseases of the Nervous System* 1960; 21:40-46.

[8] Stauss H: Das Zusammenscluecken. *Journal of Psychology and Neurology* 1929; 39:111-231.

[9] Landis C, Hunt WA: *The Startle Pattern.* New York, Farrar and Rinehard, 1939.

[10] Eysenck HJ: The learning theory model of neuroses—A new approach. *Behav Res Ther* 1976; 14:251-267.

[11] Freud S, Ferenczi S, Abraham K, et al: *Psychoanalysis and the War Neurosis.* New York, International Psychoanalytical Press, 1921.

[12] Horowitz, Mardi J: *Stress Response Syndromes.* New York, Jason Aronson Inc, 1976.

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STATEMENT OF

ARTHUR L. ARNOLD, M.D.

CHIEF, PSYCHIATRY SERVICE

VETERANS ADMINISTRATION MEDICAL CENTER

PHOENIX, ARIZONA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

March 24, 1983

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to discuss inpatient and outpatient treatment for Post Traumatic Stress Disorder in the Veterans Administration from the perspective of the field.

Mr name is Arthur L. Arnold, M.D. I graduated from the University of California School of Medicine, completed residency training in Psychiatry at the Worcester State Hospital in Worcester, Massachusetts, and in the private sector served as Chief of Psychiatry at the Lovelace Foundation and Clinic in Albuquerque, New Mexico, and Clinical Director of the Southern Minnesota Mental Health Center in Albert Lea, Minnesota. I have held teaching appointments at the University of North Carolina School of Public Health and the University of Rochester School of Medicine and Dentistry. In the public sector I have served as Associate

Director of the Michigan Department of Mental Health and Deputy Commissioner of the New York State Department of Mental Hygiene, before joining the Veterans Administration, serving as Chief of Psychiatry at the VA Medical Centers in Tacoma, Washington, Bay Pines, Florida, and presently Phoenix, Arizona. I am licensed to practice medicine in five states, certified in Psychiatry by the American Board of Psychiatry and Neurology, and have been a fellow of the American Psychiatric Association since 1969.

I knew little or nothing about the effects of combat stress on Vietnam veterans before 1979 when I was surprised by what I learned from two patients. Both had been considered to have anti-social personalities and abused alcohol and drugs. One night one of them vividly relived an experience of being under heavy enemy bombardment while apparently in his sleep; he would not talk about it. In a long conversation with the older of the two men I learned he was concealing overwhelming guilt and grief since the deaths of almost his entire company of young men in one combat engagement. It was more than a year later when he trusted me enough to tell of his participation in covert kills in villages behind the lines and his deeply troubled feelings about that.

At about that time the Vet Center opened in St. Petersburg, a few miles away, one of the first in the VA Outreach Program. I invited their staff to meet with our clinical people to discuss what they referred to as "delayed stress syndrome". Several speakers, including Dr. Art Blank, were invited to give presentations along with other clinical sessions we were conducting on the diagnosis and characteristics of Post Traumatic Stress Disorder and the nature of the Vietnam War. A Vietnam veteran on our staff had already been treating a group of Vietnam veterans in our Mental Hygiene Clinic.

We found very few articles in scientific journals on the psychiatric treatment of Vietnam combat veterans. After a few months, though, a major revision of the official diagnostic classification system of the American Psychiatric Association was published, and while preparing a lecture series on this I found that the detailed description of Post Traumatic Stress Disorder fit many of the Vietnam veterans we were just beginning to understand better. At about the same time, Dr. Jack Ewalt issued a very clear and detailed professional services letter to all the VA Medical Centers describing PTSD as it particularly applied to Vietnam veterans.

A number of senior clinicians on the staff frankly expressed reservations about PTSD, or rejected the concept entirely. Others, most of them younger and more recently trained, showed abilities in establishing good working relationships with Vietnam veterans and were astute in making the diagnosis and carrying out treatment. Vietnam veterans on the psychiatric wards became more and more resentful at what they saw as rejection by clinical staff and the inappropriateness of the usual general psychiatry treatment. I invited the interested staff to plan a more appropriate specialized approach to treatment, and when the dissatisfaction of the Vietnam veterans on the wards became seriously threatening they were also invited to make treatment program suggestions. Both groups had very similar ideas, and an initial program outline was developed.

In May, 1981, 20 of the 96 acute inpatient psychiatry beds at the VA Medical Center in Bay Pines, Florida were utilized for the treatment of Vietnam combat veterans with Post Traumatic Stress Disorder. No new, additional, or specially designated staffing or space resources were available. The multidisciplinary treatment team assignments of nearly all staff members were changed so as to bring together onto one team the staff who volunteered and were selected to work with Vietnam veterans. The other three treatment teams continued to treat the acute psychiatric patients.

The treatment program was specifically designed for Post Traumatic Stress Disorder. As you are probably all aware, this involves exposure to such extreme stress that it would psychologically wipe out almost any one, followed by disturbing vivid memories and nightmares of the experience or having some reminder trigger a reliving of the experience, including seeing or hearing parts of it as clearly as though it were happening all over again. They try to shut out the world by not feeling close to other people, not feeling emotions, and avoiding activities. This results in a whole host of other problems like guilt feelings and depression, sleeplessness, and trouble concentrating. Some use drugs or alcohol as a sort of anesthetic, some become workaholics, and others drop out completely.

The treatment is mainly to talk out the experiences which were overwhelming and gradually to come to terms with them, individually or in a group. In a specialized unit, something happens which seems to be a most important part of the recovery process: the men form a close bond with each other, confronting problems openly but also supporting one another with deep caring through the difficult times. There are a number of other aspects of the treatment program which we have described in detail in a 50-page program manual.

The program is one of the most difficult and yet most rewarding experiences any psychiatrist, psychologist, social worker, or psychiatric nurse could hope to take part in. The stress on the staff is high and burnout is a constant hazard. The management of potential violence and suicide risks keep everyone alert. It is anything but easy to deal with the problem behavior of these men in a therapeutic way and still maintain order.

We encountered a number of problems which are still not solved to everyone's satisfaction. The length of stay is long, from one to several months; this makes it uncomfortable to face the long waiting list. The sharing of space with general psychiatric programs results in frequent border skirmishes. There is a high demand for medication to ease the pain, but working through the stress seems to require relying on a minimum of medications. There are a number of readmissions of men who seemed to be doing better. There is an almost universal need for vocational rehabilitation but a frustrating lack of ability to respond. It is essential to deal with PTSD on both an inpatient and outpatient treatment basis and to coordinate this with the work of the Vet Centers and Alcoholism Rehabilitation Units, and these are too often organizationally fragmented.

A specialized unit for a veteran population which is difficult to treat could not be established and maintained without strong administrative support. If the Chief of the Psychiatry Service is knowledgeable and takes the initiative, this leadership can bring the various professional staff together and help produce a sound program plan. If the Chief of Staff and Medical Center Director are actively supportive, such a program can survive in the hospital atmosphere, where there are many competing priorities and interests. It helps, too, to have the support of the Mental Health and Behavioral Sciences Service in the Central Office for the attention which should be given to PTSD as a significant problem.

There are now eight specialized treatment units for Vietnam veterans with Post Traumatic Stress Disorder in VA Medical Centers. The oldest is also the largest: At Menlo Park Division of Palo Alto, with 90 beds. The others range from 12 to 26 beds and are all in the eastern half of the country. Except for Bay Pines, none of them have operated more than a year, all have used existing staffing, have very similar treatment programs, long waiting lists, have difficulty arranging for outpatient follow up, and work as closely as possible with the nearest Outreach Programs.

The close working relationship of these programs with the Outreach staff is essential. Vietnam veterans will approach the Vet Centers more freely, and if the hospitals are responsive the ones who really need it can be referred to the hospital for treatment. The Vet Center staff have made some heroic rescues of Vietnam veterans to get them to the hospital. They provide a support network which helps the veterans to survive in the community. The Vet Centers seem to be seeing more difficult cases now, but Mental Hygiene Clinic workload is at capacity, so there is no easy solution to outpatient treatment of Post Traumatic Stress Disorder when hospitalization can be avoided.

We need to learn more about PTSD. Particularly, we need good research studies on the effective components of the treatment program on specialized units as compared to general psychiatric wards, the functions of the brain in anxiety and sleep problems, and the relationship between different kinds of combat stress and different groups of symptoms. I have a bibliography of 250 articles with more being added continuously, but there are very few reports of carefully conducted research.

From the perspective of a psychiatrist in the field, Post Traumatic Stress Disorder is almost unique among all of the psychiatric conditions we treat because it is so clearly related to combat exposure. These are truly wounds of war, and in Psychiatry would seem to be a particular responsibility to those of us in the Veterans Administration.

Thank you for your attention. If you have any questions I will do my best to answer them.

Statement of Craig W. Burnette
Team Leader, Knoxville Vet Center
Before
The Subcommittee on Hospitals and Health Care
House Committee on Veterans' Affairs
March 24, 1983

Mr. Chairman, I would like to share with this committee what the Knoxville Vietnam Era Veterans Outreach Center has seen and is presently seeing since it opened its doors on January 9, 1982. I will also share what activities we have been and are engaged in and what we believe the future holds for the Knoxville Vet Center and the Vietnam Era Veterans we serve. In sharing these things with you I hope that I will also impart to you a sense of what kinds of problems the Vietnam Era Veterans are presenting to us and what Operation Outreach is doing to help them as they face and deal with these problems.

When the Knoxville Vet Center opened its doors, we found very quickly that the veterans coming to see us were presenting multiple problems. Many were experiencing dreams and flashbacks. They were anxious and fearful. Some of them were talking of suicide. They were concerned about Agent Orange. They had no meaningful interpersonal relationships with anyone. They were angry and embittered. They were numb and isolated from the world around them. They presented other problems such as vocational, marital, financial, legal, and substance abuse. A large number of the veterans would come in, sit down, and say, "I simply want to talk to someone. I've never had the chance, and I've always wanted it." Now many of our veterans have gone a long way toward solving the problems they have brought to us. Many still have a way to go, and we are continuing to work as hard as we can with them. I have attached to my statement some statistics we have gathered on the clients that we have seen thus far. These figures show the types and numbers of the problems I have described.

Please understand these problems I have addressed are just as real for each veteran we see today as when we opened, and that they are rooted in the military experiences of our clients. I would like to describe how our Vet Center comes into play as we work with these veterans toward resolving those deep feelings they have about their experiences either in Vietnam or during the time that they were in the military and the subsequent months and years after their Vietnam or military experience. Working with the Vietnam Era Veterans on these feelings is the essence of what we do at the Center. As you know we provide individual and group counseling at our Vet Center. We believe our rap groups are the strongest and most effective ways of treating the problems of our Vietnam Era Veterans. Since we've opened we have had a minimum of three rap groups meeting every week. These groups consist of Vietnam combat veterans, Vietnam Era Veterans, and the significant others who are involved with them. In these groups the veterans are able to release along with other feelings the anger and anguish they have felt and have held within them over the years. Too, they realize they are not alone in their feelings. If I've heard one I've heard fifty say, after hearing a veteran tell his or her story, "But I thought I was the only one who felt that way." You see Vet Centers are places where the Vietnam Era Veteran can find security and trust and can be treated with respect and dignity no matter what story is told, no matter what emotion is displayed. It is tragic that they have had to wait until now to have this opportunity to talk, but the truth is that except for self-help groups and a Disabled American Veterans project, Vet Centers are the first places that have ever addressed specifically and systematically the problems associated with their military experiences. This becomes even more obvious to me when I present workshops to mental health professionals who acknowledge that through the years they have never even considered asking a Vietnam Veteran (if they even knew the client was a veteran) about his/her military experiences. It seems there is lots of interest in the here and now and on childhood events but never the "stuff" in between. Well we are starting to change that because at our Vet Center the "stuff" is the primary thing we deal with. Over 90% of our clients are in-country Vietnam Veterans, and the majority demonstrate one or more of the criteria for Post Traumatic Stress Disorder. Also we have found that what we see is not limited to a certain socio-economic group. Our estimates are that 25-30% of our clients who are involved in long term counseling with us and who are displaying these symptoms can be classified as white collar professionals with good, steady jobs and seemingly stable relationships. I personally believe these figures would be higher if society didn't frown on "successful" people who seek counseling help.

Now I would like to comment on another way we impact on the Vietnam Era Veterans in our area. We engage in what is called networking. Over the past year we have given approximately 37 workshops and presentations to the professional and lay community. These people on numerous occasions are interacting with Vietnam Era Veterans and our workshops and presentations are designed specifically to sensitize them to issues faced by the veterans and to impart some skills in working with them. We have given these workshops and presentations to service organizations, business, church and civic groups, high school and college classes, mental health facilities, legal groups, etc. We have given numerous radio interviews and we have made television appearances. We get publicity through our local newspapers and our cable television. We are at present planning two large workshops to be given in Nashville and Knoxville, Tennessee. At these a nationally recognized expert will present his views and research on Post Traumatic Stress Disorder in the Vietnam Era Veteran. There is a complete list of these attached to this statement also.

As a result of this networking many Vietnam Era Veterans are referred to us for help and in turn we refer many veterans to the agencies and groups with which we have become involved. I believe our community sees the Vet Center as a positive force working in conjunction with it to effect real change in our clients. For instance, we run a substance abuse group that serves for some of the community agencies as an after care program for the Vietnam Era Veterans who are their clients.

Another way our community has responded to us is through volunteers. Mental health professionals, students at the local university, concerned individuals, and people from service agencies have freely given of their time to serve as co-leaders in our rap groups or to help with answering phones and other office duties.

Along with the networking in our local areas we have attempted to make contact with veterans in towns and communities some distance from us. We have found that over 90% of our clients live within a 40 mile radius of us. What we need is more time and staff to go out in the hills and mountains of East Tennessee. Better yet, we would like to establish satellite centers where we know there are large populations of Vietnam Era Veterans in the surrounding area. At present we are making a special effort to reach out and bring in women veterans. One of the persons on our staff has specifically started networking for this and we hope to have a group exclusively for women veterans within the next month. This personally strikes home with me as my wife is an in-country Vietnam Veteran.

Regarding our work with other Veterans Administration facilities, our Vet Center is approximately 150 miles from the Nashville Veterans Administration Medical Center, our parent facility, and approximately 130 miles from the Mountain Home Veterans Administration Medical Center. We have used these and other Veterans Administration Medical Centers extensively in treating our clients. In turn they have used us and have made very appropriate referrals. Locally we have a Veterans Administration Outpatient Clinic. Dr. Lewis Howard, Chief Medical Officer, has stated on several occasions how his problems have lessened since we opened our doors.

In the 14 months we have been in operation we have seen approximately 700 veterans and have recorded 2,400 visits by veterans and their significant others. These numbers we believe will continue on and increase as the word of our existence spreads. We believe this will occur because of our own professional and personal commitment to the program and because of the Vietnam Era Veterans themselves. I also believe that if we cease to exist we will cut off from any help a population that only a program designed like ours can reach.

At this point I must state that I believe for this program to continue to be successful in drawing on its targeted population it must remain non-traditional in style. We must continue to have flexibility in our work hours. We must continue to be allowed to go where the veteran is. We must not get bogged down in a morass of paperwork thus taking away that most important ingredient that we have to give to our veterans, and that's the time to listen and deal. We must continue to have staffs who are both professionally and personally committed, and who possess the empathy and the energy necessary and needed to deal with the type of clients that we see. We cannot be seen as just another bureaucracy with the attending red tape and hassles. We must respond to our veterans like soft earth to rain as we accept and hold them and not like a concrete sidewalk that the rain bounces off of and runs away.

Given what I've put before you, the numbers of clients that we see, the kinds of issues that are brought into our Vet Center, the involvement of our community and its people, I would suggest that we along with all the other Vet Centers in the nation who are doing similar types of activities have started building a foundation. We have set up a base upon which to build a solid structure that will continue to attract and serve those Vietnam Era Veterans who need our help. This foundation can only stay solid and the structure can only grow with the continued support of the

Veterans Administration and of the Congress of the United States of America.

In closing I would like to share with you a story that I believe tells what we were, are, and will continue to be about. On January 14, 1983 a Vietnam Veteran, ex-Marine, stood before approximately 100 people as we celebrated our first year anniversary. He had been coming to our Vet Center and attending one of our rap groups for about three months. He had come to the Vet Center as a result of a speech I had made to the Kiwanis Club of which he is a member. His statement quoted in The Knoxville Journal the next day was a very simple, but profound one. He said, "I left Vietnam in 1967, but I didn't come home until 1982." Given the fact that in our area of responsibility we have seen barely one percent of the Vietnam Era Veteran population, we need the chance to continue bringing our veterans home in the coming years.

PREPARED STATEMENT OF DR. MICHAEL R. MILLER, PSYCHIATRIST-TEAM LEADER, ASSISTANT REGION VI COORDINATOR FOR COUNSELING

Veterans Administration

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In Reply Refer To:

SUBJ: Report to United States Congress, House Veterans Affairs Committee, Subcommittee on Hospital and Medical Services

1. This report is prepared in response to a request from the House Veterans Affairs Committee, Subcommittee on Hospital and Medical Services. This request was for testimony from a Team Leader from the Vet Center Program to provide information about a local Vet Center and to provide information and opinion relative to the effect or possible effects of discontinuation of the Vet Center Program. In delivering this testimony it is important to indicate the perspective from which the following information has been derived. As the author of this report, I am approaching the problem from a number of relative perspectives. First, I am a Vietnam veteran. I was in the United States Marine Corps from April, 1966 until March of 1968. During that period, I served 18 months, from September of 1966 until February of 1968, as a S and C clerk for the Marine Wing Headquarters Group 1 located in DaNang, Vietnam. Secondly, I have subsequently gone through an educational process which has culminated in psychiatric training. I graduated from a psychiatric residency at the University of Oregon Medical School in 1979. Thirdly, I have been a team leader for the Vietnam Veterans Outreach Center in Portland, Oregon for the last year. And finally, for the past two months, I have been the Acting Assistant Regional Coordinator for Clinical Services for Region 6 of the Readjustment Counseling Services.

2. The following testimony is derived from first and second hand experience. My first hand experience includes psychiatric training and experience as an Assistant Director or a 12 bed inpatient psychiatric crisis unit, and Director of Emergency Services at the University of Oregon Health Science Center from 1979 until 1981. In that role, I saw numerous Vietnam veterans appear at the Emergency Room and a number of those veterans in an inpatient setting for acute psychiatric crisis. Beginning in November of 1979, I started a Vietnam veterans "rap" group at the Vancouver Division of the Portland VAMC and have facilitated that group continuously for the past three years. Beginning in April of 1982, I assumed the role of Team Leader at the Portland Vets Center, and in that position have dealt on a fulltime basis with Vietnam veterans and their readjustment issues. During that period, I have had the opportunity to assess the readjustment issues of some 100 Vietnam veterans through intake processes, crisis intervention, ongoing psychotherapy, and group facilitation roles. Additionally, I have conducted the administrative functions of the Vet Center and its liaison roles with the local VAMC and community agencies over the past year.

3. In my role as Team Leader I have been required to make a historical review of the Portland Vet Center to evaluate its progress and to recommend its ongoing staffing and development. From this perspective I have reviewed the historical information related to the number of clients, the types of counselling, the various modalities of outreach and community networking. And recently as Acting Assistant Regional Coordinator for Counseling Services, have evaluated the statistics from Region 6 of the Readjustment Counseling Services.

4. The following testimony is my assessment and best opinion of the Portland Vet Center and the Readjustment Counseling Service from its inception in November of 1979 to the present day. Included are evaluations and opinions about the directions necessary to fulfill the original legislative mission of providing readjustment counselling services to all Vietnam veterans who potentially would be in need of those services.

MICHAEL R. MILLER, M.D.
Psychiatrist/Team Leader
Assistant Region VI Coordinator
Counseling Services

VET CENTER HISTORICAL PERSPECTIVE

The Vet Center is a Veterans Administration funded readjustment counselling center for veterans of the Vietnam era (August, 1964-May 1975) and was authorized originally by Public Law 96-22 and extended through Public Law 97-72. This legislation was enacted after numerous studies had indicated that Vietnam era veterans were experiencing numerous socio-psychological difficulties unique to their situation. These studies further indicated that the Vietnam era veteran was extremely reticient to seek assistance through traditional veterans organization and that a non-traditional approach might be more appropriate to reach this population.

The Vet Center assists those veterans who have failed to make adequate socio-psychological adjustment to and re-entry into civilian life by providing assistance in utilizing their veterans benefits and existing VA facilities and by providing readjustment counselling in an attempt to facilitate a more positive adjustment to their current life space and environment.

General mental and psychological assessment, mental health services (if appropriate), and readjustment counselling (individual, group, and conjoint) are available for any eligible veteran who served on active duty at any time during the Vietnam era. Veterans requesting assistance with employment/career exploration, discharge-upgrading, or benefits counselling are referred by our office to other appropriate agencies, with Vet Center followup.

The Veterans Administrative Readjustment Counselling Service Portland Vet Center is located at 2450 SE Belmont, Portland, Oregon. This office is situated as a storefront outreach, located separate from the VAMC facility. The Portland Vet Center (#617) is located in a catchment area with 50,000

Vietnam era veterans in its immediate geographic area, and some 110,000 Vietnam era veterans in its larger delegated outreach area. The Portland Vet Center initiated operations in February, 1980 with a staff of four persons and 2200 square feet of space (1900 usable as office/counselling). The office is the downstairs of a two-story corner structure and was projected to serve approximately 230 clients per month. This space was expanded in January of 1983 to include 1100 square feet in an upstairs apartment to accommodate a client load that had grown to greater than 400 clients per month. The physical setting for the Vet Center is non-traditional and "storefront" in nature and presently includes three private counselling offices, two large group counselling rooms, a large resource area, two separate bathrooms on the ground floor, with a bathroom upstairs, a small kitchen and reception area. The entire downstairs portion of the building is accessible to handicap individuals with public transportation right outside the front door.

The Portland Vet Center has primary responsibilities for referral acceptance and outreach responsibilities for an area including some 30,000 square miles. This includes four southwest Washington counties and 16 northwest Oregon counties. This region includes the northern Williamette Valley, the most densely populated area of Oregon and includes coastal areas of Oregon and southwest Washington in addition to central mountain counties along the Cascade Range.

STATISTICAL REVIEW

The following is a review of present statistical performance and an analysis of counselling efforts to date.

Outreach efforts are reflected in new client members:

324 new clients in first seven months--46 per month

484 new clients in FY 81--40 per month

418 new clients in FY 82--35 per month

The primary mission of the Portland Vet Center was perceived as readjustment counselling and group counselling was initiated early to complement individual and crisis intervention. By the beginning of FY 81, nine (9) ongoing groups were activated. Presently twelve (12) ongoing groups are active per week.

Early outreach efforts to areas south and north of Portland initiated group Vietnam veteran readjustment counselling groups in Salem, Oregon. Salem is the State Capitol, a city of greater than 100,000 persons, located some 40 miles south of metropolitan Portland. These groups later became a separate veterans organization, the Oregon Veterans Leadership Conference (OVLC). The OVLC has recently floundered, secondary to insufficient leadership and an inability of the Portland Vet Center to give adequate support because of increasing workloads in the Portland area.

Groups were also established in Eugene, Oregon. Eugene is a city of 150,000 persons located at the southern end of the Willamette Valley, some 100 miles south of metropolitan Portland. In 1981 the groups in Eugene were complimented by the establishment of an additional Vet Center (#626).

In central Oregon the main population center of Bend, some 2 1/2 hours driving time from metropolitan Portland were also targeted for readjustment counselling groups. These groups were initially implemented by the Portland staff and later supported by the Eugene Vet Center staff. These Readjustment Counselling Services have recently received local support through two contract fee persons, contracted through the Portland Vet Center and Portland VAMC.

The geographical constraints to travel from the coastal regions have necessitated using contract fee persons in the coastal cities of Astoria and Newport, Oregon. Also, the Columbia River Gorge is presently being served by a contract fee person in the city of The Dalles, some 100 miles east of Portland on Interstate 84.

The Portland Vet Center statistics reflect a continuously increasing workload. Fiscal Year 1981, the first full year of operation, showed:

3,957 total visits with 25,646 total contacts

2,974 telephone contacts

This represents 330 visits per month

Typical of the national model, Portland began with four team members representing 2.0 FTEE of counselling. Productivity standards adopted in FY 81 indicated a standard of 112 visits per month per FTEE of counselling. The above figures for the first year of operation indicate a client visitation rate equaling 3.0 FTEE workload compared to the 2.0 FTEE assigned. This represents 50% greater workload than allotted FTEE in the first full year of operation.

FY 82 showed:

4,790 visits with 33,127 contacts

1,747 telephone contacts

400 visits per month which equals 3.6 FTEE workload

This represents a 75% greater than allotted FTEE allowances.

Analysis of these basic statistics reveal a number of important issues:

1. In Fiscal Year 1982 figures showed 630 different veterans seen on 3,992 separate visits;

   (a) 4,790 minus 3,992 equals 798 collateral visits, which reflect an ongoing program to provide counselling to significant others primarily through group counselling. This material will be further elaborated in a later section of this paper.

   (b) The Portland Vet Center experience with groups of significant-others of veterans has been documented in an unpublished manuscript authored by Bari Fisher, Readjustment Counselling Outreach Tech/Office Administrator of the Portland Vet Center.

2. 3,992 visits for 630 veterans indicates an average of almost seven visits per client:

   (a) Preliminary Outcome Studies of new clients show a distinct bimodal distribution with approximately 50% of new clients seen one, two or three times, and 50% seen at a rate approximating 12 visits per year. Random chart reviews of these two populations of clients indicate that approximately half of the Portland Vet Center clients utilize the Vet Center for crisis intervention, benefits counselling, or employment issues. The remaining 50% of clients utilize the Center as primarily a counselling facility, attending individual or group counselling sessions on a regular basis.

(b) Comparing these statistics to the basic therapy model utilized at the Portland Vet Center, a 12-week "rap" group counselling program or 10 to 12 individual sessions, implies a high compliance and low dropout rate for those clients that stay beyond initial intake or crisis intervention.

Therefore, pending definitive outcome evaluation studies still to be implemented, the above statistics show:

1. That the intended mission of a course of readjustment counselling has been accomplished at the Portland Vet Center.

2. Additionally, the statistics indicate that the workload has stayed high at greater than 75% above FTEE allowances.

3. Decreasing new client rates which were previously indicated as:

46 clients per month in FY 80
40 clients per month in FY 81
35 clients per month in FY 82

reflect the strain of an increasing active client load. Then as the workload of counselling increases, the emphasis on outreach correspondingly has to decrease.

These statistics strongly imply a counselling system that does quality work--high number of clients going completely through the counselling program--but that is operating at or beyond maximum capacity. That the decreasing rate of new clients does not reflect a decreasing need is apparent from:

1. The total number of veterans in the catchment area, 55,000 veterans within a half hour drive of the Portland Vet Center by demographic estimates, would by national averages imply some 15,000 Vietnam veterans requiring readjustment counselling services compared to 1300 total clients presently entered into the system to date;
2. A surge of new client contacts whenever regular public service announcements and regular outreach efforts are supplemented by national or local publicity of the Vietnam issues or the Portland Vet Center;
3. A dramatic response to the initiation of the contract fee service program in outlying areas.

INNOVATIVE AUGMENTATION OF STAFF

To date the Portland Vet Center has utilized many alternatives to provide additional readjustment counselling services:

1. Volunteer staff
    - a. Presently nine Vietnam veterans who are graduates of the Readjustment Group Counselling Program at the Portland Vet Center, co-facilitate with counsellors the Vietnam veteran "rap" groups.
    - b. Seven volunteer professionals from the Portland VAMC, the Oregon Health Sciences University, and private practice co-facilitate "rap" groups, see clients on a one-to-one basis, and help with counselling couples and families.

2. Liaison with the VA Outpatient Clinic has resulted in acceptance of Vet Center clients for individual, family and couples counselling. An additional Vietnam veterans readjustment "rap" group is run at the Outpatient Clinic with a Vet Center staff member co-facilitating with an Outpatient Clinic staff member.

3. All medication evaluations, prescriptions and medication follow-up are conducted at the VA Outpatient Clinic.

4. The Portland Vet Center has utilized the State DVOP (Disabled Veterans Outreach Project) staff person as primary employment counselling service. This person is now located at the Vet Center one-half time by signed letter of agreement with the Oregon State Employment Division.

5. The Portland Vet Center utilizes the Regional Office and local veterans service organizations to conduct all benefits and compensation counselling. Additionally, the American Red Cross and other veterans organizations are utilized for all discharge upgrade services.

6. Drug and alcohol abuse counselling is organized through liaison with local community and VAMC alcohol and drug programs.

Augmentation of staff is not without cost. All of the above utilization of volunteer, VAMC and community resources results in checking, supervision, and coordination to insure follow-up. This is done informally and in time blocks of 5, 10 and no more than 15 minutes. This is rarely logged as client contact due to the inefficiency of using time for paperwork that is already badly needed for counselling efforts.

Statistical Conclusions:

1. Analysis of the statistical information available to the Portland Vet Center reveals a potential client population of 50,000 Vietnam era veterans in the immediate locale. By national statistics this would reveal some 20,000 Vietnam theatre veterans which by national studies would imply some 7,000 veterans to be contacted and offered readjustment counselling services.

2. The Portland Vet Center has, through: (a) its vigorous outreach efforts; (b) utilization of group counselling as basic treatment modality; (c) cultivation of volunteer staff; and, (d) liaison with VAMC and community services attempted to maximize the readjustment counselling services available to Vietnam era veterans in its catchment area. Despite these efforts, to date only an approximate 15% of potential clients have been entered into the system.

3. Evaluation of the Portland Vet Center staff utilization has indicated a staff productivity far exceeding national productivity standards. This counselling program that is at a maximum of service delivery can, at the present staff strength, reasonably enter only approximately 400 new clients per year of the remaining 7-8,000 Vietnam theatre veterans in this area estimated to need readjustment counselling services.

DESCRIPTION OF CLIENT PRESENTATION

The Portland Vet Center has, over the past three years, entered into their client contact number system over 1300 Vietnam era veterans. These veterans were the subject of a preliminary random chart review by Vet Center staff and volunteers over the past six months. A number of tentative observations came from that analysis:

1. 95% of visits to the Portland Vet Center were by "theatre" veterans. That is, veterans who served at least part of their service obligation in a combat zone, primarily stationed in Vietnam. Some of them were stationed in Okinawa and Japan going to Vietnam TDY, and some of them were involved in naval operations off the shores of Vietnam.

2. A substantial percentage (40% to 50%) of Portland Vet Center clients were assessed at their initial intake as showing signs of Post-Traumatic Stress Disorder (PTSD) per DSM III criteria.

3. An additional 20 to 25 percent of Vet Center clients showed signs and symptoms of possible Post-Traumatic Stress Disorder (PTSD) that were judged to be partially covered by use of drugs and/or alcohol.

4. 60% of Portland Vet Center clients were noted to require extensive psychological counselling, as defined by having ongoing services on a one-to-one or group basis for greater than a two-month period.

5. 33% of Portland Vet Center clients seen in 1982 presented with moderate to severe employment problems.

6. 65% of those client's charts reviewed indicated serious marital and/or relationship difficulties.

7. An ever increasing number of clients on the active caseload of the Portland Vet Center had multiple problem areas which required ongoing counseling and/or case management to derive a satisfactory outcome.

8. Despite the above statistics, fully 25% of new clients in the past six months indicated that their contact with the Vet Center had been their first step in talking or coming to grips with their Vietnam experiences.

9. 50% of the new clients indicated that they had only recently become aware of the availability of readjustment counselling services through the Vet Center program.

A review of the above listed statistics indicates that the Portland Vet Center client population appears to be typical of the Vet Center clientele nationwide. This is based on a recent review of client statistics conducted by Readjustment Counselling Services, Central Office. Additionally, it is noted that a good number of veterans who appear for readjustment counselling services at the Portland Vet Center have only recently become aware of the availability of those services through the Vet Center program. Also, it is noted that an ever increasing number of clients on the active caseload constitute a multiple problem list clientele which requires ever increasing staff time and effort to provide a reasonable readjustment.

Outcome statistics for the Vet Center Readjustment Counselling Services have not been addressed. No definitive studies have been done nor has the staff or monies been appropriated to date to conduct a systematic outcome evaluation. In lieu of the capability to do outcome studies random client review, and client satisfaction questionnaires have been sent out from the Portland and Seattle Vet Centers. The return rate at present is far below 50% and, although overwhelming positive in their comments, very possibly reflects only satisfied customers.

Feedback for staff on programmatic issues is a dire necessity for the Vet Center system and the Portland Vet Center in particular to be able to refine their counselling efforts to provide the maximum benefit to Vietnam veterans requiring readjustment services. In the original Vet Center design, research and program development staff were included. Their absence is the single greatest deficiency of the program as legislated.

VET CENTER STAFF

The staff development and turnover at the Portland Vet Center is revealing of the requirements necessary to generate a well qualified and sophisticated group of counselling persons. It is also revealing of the particular stresses and negative effects that outreach counselling services have on staff members.

The original team of the Portland Vet Center consisted of a team leader who was a clinical psychologist, Vietnam-era veteran, with 10 years active duty in the Air Force. He had experience counselling returning Vietnam veterans and had personal experience through friends who had been killed or wounded in Vietnam. He was instrumental in establishing the Portland Vet Center both in its present location and situation, and in developing an excellent liaison with the local Portland VAMC. But after two years of service at the Portland Vet Center, he had to leave because of the stresses that the long hours placed on his family. He returned to active duty in the Air Force.

The original clerical staff person was unable to deal with the crisis and walk-in situations and after four months was terminated.

The original two outreach specialists positions were staffed by persons coming from Project Return, a community base organization that specialized in job assistance plus some counselling and guidance about benefits to Vietnam veterans. One of those counselors after a year and half quit the Vet Center program due to the long and unusual hours and went into private business. The second counselor is the only remaining member of the original team and has developed his own educational background through academic coursework to the point of a masters degree in rehabilitation counselling. He also is presently involved in a study at the Portland VAMC that is co-authored by two staff psychiatrists and which is scheduled to be read as a paper at the May, 1983 American Psychiatric Association National Meeting in New York City.

The two persons who replaced the clerical position and the counselling position also both have developed their educational backgrounds during their period at the Portland Vet Center. The administrative clerical position has been developed into a partial administrative position and partial counselling position. This has helped to extend the services to significant others to the present two groups per week. The three volunteer co-facilitators are also supervised by this clerical/counselling person.

The second outreach specialist position has been filled by a Vietnam veteran who originally developed his counselling skills in the correctional and mental health system and subsequently entered a doctoral psychology program prior to his employment at the Vet Center. He has developed his academic interests through the Portland Vet Center in the areas of programmatic evaluation and outcome research. As the replacement Team Leader, I came in with a psychiatric background and have developed an interest in clinical assessment and service delivery which has developed into a Assistant Regional Coordinator position for counselling services.

The above review of the staff development of the Portland Vet Center indicates that the stresses of time and workload often lead to staff turnover and personnel loss. It also indicates that personal development, especially in areas of academic interest or personal projects, tend to foster continued involvement with readjustment counselling services and Vet Centers in particular.

There are a number of positive and negative factors to be weighed in evaluating the staff situation within the Vet Center program. On the positive side:

1. staff dedication appears to be very high.
    a. Turnover has been within reasonable limits, less than might be expected in a community based high stress situation, especially considering the irregular work hours and the heavy caseloads.
    b. The recognized expertise of Vet Center employees in dealing with Vietnam veterans in general and readjustment and post traumatic stress disorders in particular has created a esprit de corps that appears to create a type of group unity.
2. Staff development of volunteer and trainee programs in order to augment their clinical service delivery has been instrumental in increasing the source of potential Vet Center staff and increasing the interest and awareness of readjustment disorder problems among VA staff and developing mental health specialists.
3. Along those same lines, training within the community has grown considerably with requests coming now from specialized organizations such as the police and fire departments. Most community mental health agencies appear aware and interested in the specialized knowledge that has been gained within the Vet Centers.

Negative factors which impinge on staff stability include:

1. the increasing numbers of multiple problem clients. These weigh heavily both on time and satisfactory outcome situations. Such longer term clients tend to decrease staff's perception of success. Therefore, tend to increase the sense of frustration and can lead to burnout.

2. A second factor, that can be extremely discouraging to Vet Center staff is the low average General Schedule (GS) ratings for Vet Center staff employees as compared to comparable workloads and responsibility levels within the VA itself. The source of this problem appears to be the ongoing need to define the outreach specialist position on a case-by-case basis along the parimeters of long established and well defined VA positions. The innovative and unique aspects of the outreach services are often misunderstood or not generally appreciated.

3. A third, and by far the most devastating negative influence on Vet Center staff is the inherent job instability of a program funded on a temporary basis. The Schedule A status of a majority of Vet Center employees leaves them highly vulnerable during periods of public debate involving VA administration, OMB and legislative fiscal restraints. A number of dedicated and experienced Vet Center employees have already opted out of the program and a larger number have indicated that they have been contemplating leaving the program to insure themselves job stability and their families financial security. This lose of experienced and established community connections is costly to a program based on specialized expertise and community networks for success.

4. A fourth issue is the vast array of services the veterans need and the insufficient information available. This leads to extensive requests to Vet Centers to provide information, referrals, and letters of reference to community agencies about clients, plus requests to do advocacy and case management. As previously described, most of these services fall within the scope of described readjustment counselling services. The range of expertise necessary to effectively accomplish these various roles exerts special demands on outreach counselors. Under the present model of four person teams, time becomes a paramount issue. The pressure of the number of requests, averaging two to three per day or 10-15 per week at this Center, places a direct burden on counselors to provide timely responses. Therefore, the rapidity that counselors change focus and bring different information and paradigms to bear on the various problems leads to a high degree of stress. Thus, the versatility of the Vet Center counselors, at once a great strength of the program, does through constant high volume of utilization, lead to stress problems among Vet Center staff.

SPECIAL PROGRAMS

SIGNIFICANT-OTHERS. Early in the program the effect that readjustment problems had on the interrelationship between the veteran and his family were noted. Network theory and investigations have shown the effect of stress on the breakdown of networks and social support systems. These have also shown the positive effect of intact, large, diverse, stable and supportive networks in resisting negative responses to stress. Recent evidence indicates that the presence or absence of a supportive environment (i.e., one that can listen to the veteran's report of factual incidents, and accept his reaction to his Vietnam experience as valid) can be a strong predictive factor in the avoidance of long lasting readjustment problems. Therefore, early in the outreach program, significant others and families of veterans were targeted as persons to be included in the counselling efforts directed towards Vietnam veterans readjustment. Significant others rap groups have become a dominate modality in providing services to the partners of Vietnam veterans. These groups have at once provided support, information, and a forum for processing the changes that the veteran was going through via his readjustment counselling process.

CONTRACT FEES

Contract fees have been a mixed blessing. The contract fee program was initiated at this Center in May of 1983. Initial RFPs were sent. proposals received and contracts awarded by July, 1983. Six providers in five population centers of northwest Oregon were identified and awarded contracts.

No proposed contract provider had all the requisite training. Five of the six had experience working with Vietnam veterans and one of the six was a Vietnam combat veteran himself. Training was initiated through an inservice put on by the Portland Vet Center in late July, 1983. This was an all day training workshop with both didactics and experiencial components. Staff from the VAMC in Portland were cooperative in coming down and helping us with the training.

Since the initiation of referrals to the contractors in August of 1983, the program has grown from an initial estimated $25,000 per quarter to a present slightly greater than $50,000 per quarter. The total number of vets referred approaches 100 at this time. Monthly billings indicate an average of 65 to 70 vets seen per month. Each vet is seen approximately four times per month, or once per week. Special authorizations for conjoint visits have been in increasing demand, and one contractor in this area has sent a letter to Central Office indicating the dire need for significant others groups or other treatment modalities for families of veterans.

The general feedback from the field is moderately favorable towards contract persons although anecdotal to date. The cost factor has risen to approximately $200,000 per year. This is taking care of an estimated 70 clients on an ongoing basis. Translated into the average length of treatment, this results in an estimated 250 to 300 clients per year to be seen by the contract personnel. At an estimated cost of $200,000 to $225,000 per year, this is approximately the same cost that the Vet Center itself requires for one year's operation. Comparing figures of the number clients seen and the number of visits indicates that contract fees in the northwest Oregon area are running at approximately twice the price per visit as being seen at the Vet Center.

The advantages of contract fees are obvious. The geographic location of the Portland Vet Center in Portland, Oregon, is in the heart of the largest metropolitan area. The catchment area for the Portland Vet Center is greater than 30,000 square miles with two mountain ranges. The length and breadth of that area is greater than 150 miles in any direction. These distances and geographic considerations prohibit travel by veterans to the Portland Vet Center. At present, there is no money available to the veteran to subsidize that travel. Under these considerations out stationing personnel to provide readjustment counselling is important. It might be considered that out stationing Vet Center personnel in either satellite Vet Centers or in mental health or other community facilities, on a permanent or semi-permanent basis, might be a more cost effective way of providing readjustment counselling to veterans in a large rural catchment area.

The constraints and problems of contract fees are numerous. The contract fee program is, first of all, a new program to the Vet Center operation. Any new program requires a start-up period, which has traditional difficulties in program development and coordination. The contract fee program has been no different. The numerous agencies within the VAMC that have been required to learn a new process, especially a unique one, have drained considerable time from Vet Center personnel to provide an efficient transition. Contract fees requires MAS, Fiscal, Supply, and RAO cooperation. The cooperative efforts of those persons and those services within the Portland VAMC needs to be acknowledged. The difficulties that have arisen have not been because of poor cooperation, but have been because of the unique and non-traditional nature of readjustment counselling services, and the manner in which the contract fees have been established. Especially difficult for MAS has been the confidentiality issue of Vietnam veterans requesting to be seen on a timely basis without three to four weeks administrative checking into their records. Secondly, Fiscal Service has had a difficult time with the rapidly escalating costs of especially a new and as yet unproven program. Supply, by far, the most cooperative and yet receiving the most demands both from the Vet Center and the contractors, has been given the difficult task of soliciting, procuring, awarding and monitoring contracts.

Staff time has again been the greatest cost to the Vet Center Program. In Portland, as in most contract fee programs, the Team Leader was designated the COTR. This role has led to large drains on staff time This amounts to 15 hours per week when all facets of operations are included This represents approximately 20% of the total administative time of a four person Vet Center staff. No provision of extra staff to accomplish this job have been made or are any available in the foreseeable future.

Conclusions to be drawn from the Portland Vet Center experience in contract fees are as follows:

1. Contract fees do provide readjustment counselling to outlying areas.
2. Administration of the contract fee program has consumed 20% of total Vet Center staff administrative time This often can encroach on available counselling time.
3. Contract fees cost approximately twice as much to provide readjustment counselling services as do Vet Center personnel.
4. Start up difficulties of any program require a period of adjustment. Contract fees have been no different.
5. Out stationing Vet Center personnel or establishing satellite Vet Centers would be a more efficient and cost effective mechanism to provide readjustment counselling to a rural catchment area.

burden on the nuclear staffs already limited time. Documentation of these brief and varied consultation and liaison activities are an inefficient use of staff time. Recommendations would be to establish block times for this type of activity to allow their continuation and justification.

7. The vast array of services that Vietnam vets require, and the various agencies through which these services are often procured, leads directly to the necessity of Vet Center staff's being highly versatile. As earlier described. this versatility, at once a strength of Vet Center staff, can often become an eventual undoing of their strong commitment. As caseloads grow, and the more serious and chronic problems accumulate, the utilization rate of these various Vet Center staff functions dramatically increases. An increase in average staff size would allow some of these various functions to be subsumed under specific staff member specializations.

8. The vast amount of experience within the Vet Center's staff is a real asset This experience and expertise in addition to community liaisons has been accumulated slowly and painstakingly over time. Staff turnover because of job insecurity and/or excessive stress leading to burnout, is a serious cost to the program in general.

9. Vet Center programmatic focus on veterans families and significant others has lead to the beneficial incorporation of significant others into the counselling program at the Vet Centers. Significant others groups have become the dominant modality for providing this service The experience gained in dealing with the whole family unit is also an asset incorporated in the Vet Center staff at present.

10. Contract fee program has been an adjunct to providing services to Vietnam veterans in outlying areas. Its initiation has had a normal series of administrative difficulties. Its overall cost effectiveness is highly questionable. The present time costs in administrating the program are prohibitive without staff augmentation.

In general conclusion, the Vietnam veteran constitutes at present the next generation of VA client. Traditional approaches to service provision have proved difficult. Non-traditional outreach and community based service provision has proved to be a viable and effective means to provide both readjustment counselling and liaison with both VAMC and community based service organizations. The Vietnam veteran has responded both initially and over the extended period of time, in a continuous and positive way to the Vet Center program. Within the Vet Center program is incorporated numerous informational and programmatic assets that would be lost if the program were to discontinue. For all of these reasons, I feel that the continuation of the Vet Center program is imperative and the augmentation of present staffs is extremely important.

Thank you very much for the opportunity to share this information and express these opinions.

MICHAEL R. MILLER, M.D.
Psychiatrist/Team Leader
ting Assistant Regional VI Coordinator
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STATEMENT OF
D. EARL BROWN, M.D.,
ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR,
DEPARTMENT OF MEDICINE AND SURGERY,
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

MARCH 24, 1983

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear before you today to present our views on H.R. 1443, a bill, "To amend title 38, United States Code, to extend by one year the period during which Vietnam-era veterans may request psychological readjustment counseling from the Veterans Administration and to direct the Administrator of Veterans' Affairs to carry out a comprehensive study of the prevalence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans."

H.R. 1443 would amend section 612A of title 38, USC, to extend by one year the period during which Vietnam-era veterans may request psychological readjustment counseling, from September 30, 1984 to September 30, 1985. The bill would also extend by one year the provision requiring a transition of readjustment counseling program operations from VA's "Vet Centers" to VA Medical Centers and other health care facilities. H.R. 1443 would also require the Administrator to conduct a detailed, comprehensive study of the prevalence and incidence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans as well as a survey of the health status of that population in relation to that of the general population.

In essence, we support the purposes of H.R. 1443 and certainly expect to work closely with this committee on this important area. The VA recognizes the value of the readjustment counseling program and is strongly committed to it. It should be noted that those Vietnam-era veterans who have requested readjustment counseling services before September 30, 1984, and continue to need those services after that date remain eligible under the law. The mechanisms by which those services will be provided after that date have not yet been established. Although we have formed an Agency task force to address the many issues raised by that statutory mandate, we have experienced a continuing increase in the counseling workload which suggests there remains an unmet need. Our efforts to plan for the future of this program are still at a relatively early stage. I would anticipate, however, that, subject to the task force's ultimate findings and the recommendations of the Chief Medical Director, we would look favorably upon such an extension. That extension would allow us to conduct a thorough evaluation of the readjustment needs both of veterans using our Vet Centers and the needs of those who have not yet sought such services. Subject to the same qualification, we have no objection to the proposed one-year extension of the eligibility period. Although the numbers of additional Vietnam-era veterans who might seek these services for the first time after September 1984 may not be large, this program has demonstrated its capacity to provide needed assistance, and a one-year expansion of the period within which such veterans may make an initial application for these services may be warranted.

Section 2 of the bill would require that the VA conduct a truly comprehensive survey and provide Congress a detailed report on its findings and conclusions by December 31, 1984. The bill calls for a survey both of Vietnam-era veterans' readjustment and of their general health status. The measure would require that the readjustment portion of the study include a psychological evaluation of the population of Vietnam-era veterans; an economic evaluation in terms of income level and employment achievement and satisfaction; and a sociological evaluation, the focus of which would include the extent and incidence of the long-term effect on family members of post-traumatic stress disorders (PTSD) among Vietnam-era veterans. The bill would require that the survey be designed to yield data to assist in determining whether there is a correlation between the occurrence of PTSD in such veterans and (1) alcohol or drug abuse and (2) the incarceration of such veterans in penal institutions.

Under the bill, both the readjustment portion of the study and the health status portion must be designed to develop separate findings for veterans with service-connected disabilities, "Vietnam-theater" veterans and women veterans. The bill also provides that the health status portion of the study must survey both the current and "past health status" of Vietnam-era veterans and must be designed to determine the extent of and relationship, if any, between the occurrence of PTSD and related psychological disorders within that population and the occurrence of "psychobiological" or medical disorders within that population.

The Lou Harris and Associates study of public perceptions of Vietnam veterans in October 1979 produced considerable information on the socioeconomic status of Vietnam veterans. A more-comprehensive study published in March 1981 by the Centers for Policy Research covered Vietnam veterans' income levels, employment achievements and job status, incidence of alcohol and drug abuse, number of arrests and many other elements related to the psychosocial adjustment of Vietnam-era veterans.

Both from these studies and from our experience in the readjustment counseling program, we in the VA already have a significant body of information about the Vietnam-era veteran. While there is much merit to expanding our understanding of the status of these veterans' readjustment, it is very unlikely that the study required by H.R. 1443 could be designed, conducted, and a report completed in the time required by the bill. For planning purposes, such timeliness would be essential.

Both its breadth and the technical research problems it would pose strongly suggest that even if the requirements could be accomplished in the time imposed, its cost would be prohibitive. If further study on Vietnam-era veterans is to be conducted, we would urge that the Agency have discretion as to its design so that congressional and Agency concerns can be addressed in a timely manner.

Mr. Chairman, I turn now to update the committee on the status of the readjustment counseling program and other matters in which you expressed interest. All Vet Centers are now fully operational, the last two having opened during January 1983, bringing the total to 136. As of March 1983, the 136 Vet Centers have been operating for an average of two years and four months. The 28 centers which opened during Calendar Year 1982 have been open an average of 11.5 months. The other major arm of the program -- the fee-for-service contract -- is also now operational and working smoothly overall. Approximately 6,000 veterans and family members have been referred to the nearly 400 private service providers who have been awarded contract provider status. The heaviest utilization of this component is in the following areas: Upstate New York, West Virginia, Western Oregon, Ohio, Colorado, North Carolina, Montana, Florida, Eastern Pennsylvania, Wisconsin, Alabama, Virginia, and Nebraska. Contracts are still being awarded, however, and veterans and families are still learning about the program. We expect that $7 to $8 million will be utilized in the contracts program this fiscal year, and the full earmarked $11.2 million should be used during Fiscal Year 1984. Keeping in mind that the cost per visit to contract providers is somewhat higher than that for Vet Centers, it can be said that the contracts program is proving to be a modest, useful, but somewhat expensive supplement to the Vet Center modality.

Progress has been made concerning the Vet Center program, as well. Staff development in the field and in Central Office and strengthening of management controls have progressed considerably during the past 18 months. We have increased the number of program operating officials in VA Central Office from three to five, and the number of supervising officials in each region from one to three. The professional status of Vet Center staffs is slowly increasing as a matter of policy, and at present, 51 percent of service providers at the Vet Center level have mental health or human services degrees of some type, and 25 percent are mental health professionals (clinical or counseling psychologists or psychiatric social workers).

The Department of Medicine and Surgery continues to treat Vietnam veterans in medicine, surgery and psychiatry. While the most-frequently diagnosed conditions for all veterans in mental health programs continues to be alcoholism, schizophrenia and depression, 1,296 Vietnam veterans received hospital care for Post-Traumatic Stress Disorder last year. Inpatient programs for Post Traumatic Stress Disorder have been developed at eight medical centers with a total of 238 beds dedicated to treating this disorder. Other facilities provide special groups and activities for Vietnam veterans without designating these activities as special programs. Both the inpatient program and the outpatient activities have been very busy. Requests for these services have grown steadily.

Our counseling experience to date has shown that veterans coming to Vet Centers are experiencing more severe problems than we originally anticipated. As a manifestation of the unexpected severity of problems, we are finding at present that approximately 50 percent of these veterans require counseling over a period longer than 60 days. About 12 percent are being referred for psychiatric hospitalization, and about 14 percent are being referred for treatment at a VA Mental Hygiene Clinic. We estimate that 26 percent of clients come for counseling with moderate to severe employment difficulties, and that approximately 76 percent of those have been helped to secure steady employment. In this connection also, 120 Department of Labor Disabled Veteran Outreach Counselors (DVOCs) are now working part-time in VA Vet Centers.

Integration of the Vet Center program into the Department of Medicine and Surgery mainstream has been accomplished. As of January 1983, 107 VA Medical Center mental health professionals were working part-time, often as volunteers and frequently as a part of their regular tours of duty, in Vet Centers. Community responsiveness to the Vet Center program has also been demonstrated among private sector professionals. As of January 1983, approximately 126 mental health professionals from the private sector were participating in Vet Center work through the Volunteer Service.

The interest of the public in this program is further being demonstrated by the participation of both work-study students and nonprofessional volunteers in Vet Center services. As of January 1983, an estimated 335 work-study students and 365 nonprofessional volunteers from the community were assisting Vet Center staffs. Many of the latter group come from veterans service organizations, both the long-standing service organizations and the newer Vietnam veteran organizations.

Mr. Chairman, I would like now to briefly summarize some major program accomplishments of the past 12 months:

The Readjustment Counseling program has been reorganized as an independent professional service in VA Central Office. A new Director has been appointed, and Central Office staff increased. Three new Assistant Directors have been hired, one each for Counseling Services, Program Management, and Administration and Development. One secretary and two Assistant Coordinators have been added to each of six Regional Coordinators staffs to provide improved clinical and administrative supervision of Vet Centers. In June 1982, a new program circular was issued which clarified Central Office direction. It has largely ended prior conflicts and misconceptions in the field over lines of authority and program administration issues. The first Readjustment Counseling Program Guide has been published and disseminated to the field and it has been followed by the issuance of two detailed policy directives. A systematic psychological assessment format for veterans coming for help with psychological problems has been prepared and is now being introduced.

Initial operating difficulties with the fees/contracts program have been resolved and a revised Request for Funds Proposal (RFP) protocol has been issued. Program-wide collaboration with Regional Medical Education Centers (RMECs) has been instituted for all major training activities, and systematic program-wide supervision and training in management is being provided by Central Office staff.

Mr. Chairman, this concludes my statement. I and my staff will be pleased to answer any questions you or members of the committee may have.

Department of Veterans Benefits
Veterans Administration
Washington, D.C. 20420

DVB Circular 21-82-7

May 3, 1982

POST-TRAUMATIC STRESS DISORDER RATINGS

1. The purpose of this circular is to clarify the requirements for the establishment of service connection for PTSD (post-traumatic stress disorder) and to point out problem areas we have encountered in our review of claims. Five points will be covered.

a. Objective Evidence of a Stressor in Service

(1) A considerable number of claims reviewed showed lack of objective evidence of identifiable stressors. These claims contained only the veterans' own statements, given usually many years after service and without concrete evidence in the claims folders to substantiate the statements.

(2) Objective evidence of a stressor includes, but is not limited to, official service records indicating medals or commendations awarded for combat; wounds suffered as a result of enemy action or for acts of valor; duty assignment in a grave registration unit; medical or paramedical duties on a burn ward; or experience as a prisoner of war.

b. Acceptable Diagnosis of PTSD for Rating Purposes. Many of the claims reviewed had an unacceptable diagnosis of PTSD. Generally, the diagnosis was unacceptable because the symptomatology described did not support such a diagnosis; an identifiable stressor was not shown or was not adequately described; or prior reports or history identified a type of mental disorder which could not support a diagnosis of post-traumatic stress disorder.

c. Reconciliation of Conflicting Diagnoses or Conflicting Psychiatric Reports. A large number of the claims reviewed showed a diagnosis of PTSD, but the file contained conflicting evidence (either in the service records or in medical reports or examinations) with no attempt to reconcile the evidence with the diagnosis. Some claims contained conflicting diagnoses [illegible] PTSD and anxiety neuroses, unstable personality disorder) with no request m[illegible] he VAMC to reconcile the discrepancies in the diagnoses.

d. Confusion About the Applicab[illegible]ty [illegible], Program Guide PG 21-1, Section O-12, and Information Contained in [illegible]amina[illegible] TSD

(1) Several stations have inquired as [illegible] itutes a stressor and whether it is to be limited to an immediate lif[illegible] perience.

(2) Stressors include, but are not [illegible] immediate life-threatening experiences. Examples of stres[illegible] which are not immediately life threatening include grave registration, nursing du[illegible]s in a burn ward, and POW experiences. Both DSM-III and PG 21-1, section O-12, are applicable. Stressors include incidents of armed conflict or enemy action, natural disasters, and manmade disasters (both accidental and deliberate), which occurred while on active duty.

e. Lack of Continuity. In PTSD cases, continuity is not a requirement. PTSD, as the program guide and DSM-III point out, may be established as service connected, even though a considerable period of time may have lapsed between the stressor and its chronic manifestations.

2. To summarize, three basic requirements must be met to establish service connection for PTSD:

a. Objective evidence of a life-threatening stressor in service;

b. A diagnosis of PTSD acceptable for rating purposes; and

c. Adequate findings in the clinical examination describing stressor and symptoms or manifestations. PG 21-1, section 0-12, and DSM-III provide standards and guidelines.

3. A history of a stressor as related by the veteran is, in itself, insufficient. Service records must show the veteran was wounded as a result of enemy action and/or was in combat against the enemy, was a POW, or must otherwise substantiate a stressor of sufficient gravity to evoke symptoms in almost everyone, as required by DSM-III.

4. If supportive evidence is not in file, the service department should be requested to furnish information as to duty assignments, units to which assigned, combat unit duty, Purple Heart as well as other combat medals, decorations or commendations. The veteran may also be asked to furnish any evidence in his/her possession.

5. RESCISSION: This circular is rescinded April 1, 1983.

Dorothy L. Starbuck

DOROTHY L. STARBUCK
Chief Benefits Director

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Veterans
Administration

News Release

FOR IMMEDIATE RELEASE

In response to requests from news media for comments on reports that the Grace Commission had recommended the elimination of the Veterans Administration, Administrator of Veterans Affairs Harry N. Walters made the following statement:

"A draft report from a voluntary group is no basis for speculating that serious consideration would be given to eliminating the Veterans Administration.

"When the President appointed me Administrator of Veterans Affairs, he charged me with being an advocate for veterans and veterans programs. He recognizes that VA fulfills an irreplaceable role in the lives of millions of veterans and their families.

"The roles and missions of the Veterans Administration have been reaffirmed by every Congress for the past 50 years, and there is certainly no indication that the law of the land is likely to be changed regarding this nation's commitment to veterans."

# # #

Contact: Stratton M. Appleman
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March 24, 1983

Post-Traumatic Stress Syndromes Among Vietnam Veterans: The Implications for Future Research

Testimony before the U.S. House Veteran Affairs Sub-Committee
on Hospital and Health Care
March 24, 1983

John P. Wilson, Ph.D.
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I. Introduction

The purpose of my testimony today is to briefly present a framework for understanding the nature and predictors of Post-Traumatic Stress Syndromes and Disorder (PTSD) among Vietnam veterans in order to identify key areas of research that are necessary to advance our scientific knowledge of how these stress syndromes affect the lives of these veterans and their families.

II. The Nature and Predictors of PTSD

It is my belief that PTSD is most accurately characterized as a dynamic survivor syndrome in which the veteran continues to re-experience elements of his or her experience in the Vietnam War in a variety of ways which include dreams, uncontrollable and emotionally distressing intrusive images, dissociative states of consciousness and in unconscious behavioral re-enactments of the original stressors encountered during the war. In addition, many veterans also experience psychic numbing, emotional constriction, depression, suicidal thoughts, a loss of interest in previously meaningful work, hobbies and interpersonal relationships, survivor guilt, memory impairment, problems in concentrating, physical symptoms, anger and explosive rage, alienation, mistrust of authority and others, loss of capacity for intimacy, hyperalertness, hypervigilance, the search for meaning, sleep disturbance, and approach or avoidance tendencies of stimuli with trauma-related associational value. Taken as a set these symptoms or behavioral responses define post-traumatic stress syndromes in a general way as a clinical phenomena. Although PTSD is classified as a mental disorder by the Third Diagnostic and Statistical Manual of the American

Psychiatric Association, it can also be conceptualized as the normal pattern of human adaptation to catastrophic stress which is, by definition, abnormal in nature. Stated simply, PTSD is a reactive transformative psychological process in which the survivor attempts to assimilate the profoundly stressful event into an ordered, meaningful perspective that is consonant with his or her most basic beliefs and values. Table 1 presents a typology of stress syndromes derived from the work of Wilson and Krauss (1982) and Wilson and Zigelbaum (1983). This typology of stress syndromes among Vietnam veterans is useful in identifying the various ways that Vietnam Era veterans have learned to cope with the residual and prolonged psychological effects of their military duty in Southeast Asia.

Insert Table 1 about here

Predictors of PTSD in Vietnam Veterans

As a result of a number of research studies concerned with the problems of post-war re-adjustment problems among Vietnam veterans, the predictors of the severity and the associated complications of PTSD have begun to be understood in more precise scientific, medical and clinical ways. The research findings of Wilson (1980) and Egendorf et al. (1981) have estimated that between 40-70% of the combat veterans of Vietnam suffer from PTSD. More recently, Wilson and Krauss (1982) developed the Vietnam Era Stress Inventory to measure PTSD. In their recently completed two-year national study of 114 combat veterans participating in the VA's re-adjustment counseling program, Wilson and Krauss (1982) found that PTSD was multidimensional in nature and made up of

Table 1

A Typology of Stress Response Syndromes Among Vietnam Veterans

1. Depression and Suicidal Syndrome. Person feels helpless, depressed, hopeless, dejected; a sense of loss of others; may show impacted grief and have suicidal ideations. May manifest other classical signs of depression (e.g., problems sleeping, etc.).

2. Isolation and Withdrawal Syndrome. Person may live in remote, scarcely populated areas; avoids crowds and prefers to live alone, away from others. Some prefer to live in the "woods" and maintain hyperalertness developed in Vietnam. Seeks a self-contained life-style that is under personal control.

3. Sensation Seeking Syndrome. Person fits Zuckerman's criteria of high sensation seeking. May be an "action junkie" that only feels happy, alive, and whole when engaging in thrill and adventure seeking activities analogous to those performed in Vietnam. Generally, high energy intense persons who enjoy physical danger, gambling, parchute jumping, sport diving, scuba, motorcycles, and flying. Also, may develop addictive disorder, although most likely to use marijuana and cocaine as simple psychoactive drugs rather than depressors.

4. Paranoic State Syndrome. Person tends to be angry, hostile, suspicious, irritable, and has explosive rage. Often feels exploited and persecuted by government for service in Vietnam and is overly suspicious of authority and power. May maintain a hyperalertness state of perception on a chronic basis similar to that employed in Vietnam.

5. Profound Psychic Numbing Syndrome. Person feels numb and has sense of self-continuity broken by catastrophic experience. Feels like a walking shell of former self often accompanied by loss of ego-identity. Capacity for basic hope extremely diminished. Person may show catastrophic anxiety or manifest blank, zombie stare.

6. Alienation and Cynicism Syndrome. Person is alienated and cynical about the law, the "system", the government, and authority figures. Feels outside the conventional mainstream of society. Generally, person is not depressed or preoccupied with intrusive thoughts of trauma but experiences them unconsciously. Although moral and ethnical, person typically parseeks an anti-system perspective in terms of moral reasoning.

7. Problem of Intimacy Syndrome. Person has strained interpersonal relations (object relations) and is emotionally distant despite strong needs for intimacy. Intimate relation often poses a threat and raises fear of loss of love objects again (as in Vietnam). When frustrated or under stress, person may react to normal stressors by flight or explosive fits.

8. Fusion of Stress Syndromes with Pre-morbid Disposition Syndrome. PTSD can aggravate, precipitate, and fuse with other underlying psychiatric disorders. Typically, this includes aggravating pre-morbid character disorders; causing paranoid state to become predominant and overlay PTSD. In some cases PTSD can manifest classical hysterical components, such as fugue states or amnesia reactions brought on by life stress.

9. Prosocial-humanitarian Syndrome. Person is altruistic and has transformed survivor guilt and other traumas related symptoms into a nurturing humanist orientation to others and society. Person is intense and creative. Lives with existential need to work towards ends-oriented values that promote life and self-actualization. This is, perhaps, the healthiest form of coping with the stress syndrome.

Source: John P. Wilson

seven orthogonal factors: (1) depression, identity confusion, search for meaning; (2) physical symptoms, memory impairment; (3) alienation, stigmatization, cynacism; (4) sensation seeking, authority conflict; (5) anger/rage; (6) intrusive imagery of Vietnam and (7) intimacy conflict. Further, Wilson and Krauss (1982) found that the best predictors of these seven dimensions of the stress disorder were: (1) *combat role factors* (i.e., the number, length of time in combat and subjective stress in combat); (2) *exposure to specific stressors in Vietnam* (i.e., injury, death and dying, environmental stressors of an unpredictable nature); (3) *psychological isolation at homecoming* (i.e., an inability to talk about the war, lack of emotional support, tendency towards self-containment of the experience). In support of Wilson's (1978; 1980) earlier research, the results indicated that the stressors experienced in Vietnam directly impacted on the psychosocial process of identity formation since the typical soldier was 19 years old in combat. Thus, the recent findings of Wilson and Krauss (1982) add to the massive set of significant findings reported in *Legacies of Vietnam* by Egendorf et al. (1981) *which document that the main causal variables associated with PTSD are the severity of catastrophic stress in the war and psychological isolation at homecoming*.

III. The Need for New Research Studies on PTSD in Vietnam Veterans

It would be accurate to suggest that we have just begun to understand the nature of PTSD and its manifestation in the lives of Vietnam veterans and society. It is my impression, based on nearly ten years of clinical, experimental and outreach work with Vietnam veterans, that the legacy of Vietnam reaches to depths of individual psychic functioning and to the core structures of our society in ways that are subtle, pervasive, and frightening in terms of its implications if not effaced in a healthy way. Although the full discussion of this particular issue is well beyond the scope of my testimony here today, I want to say there there seems to be a societal form of post-traumatic stress which, in some ways, parallels the individual process of assimilating a trauma. Of central importance in my view is the need to recognize how strong the forces of denial and avoidance are in the collective unconscious of our culture. To state one of my major concerns directly, I worry that continual denial by the American society is very likely to aggravate destructive forces, policies and mental health care systems which will only contribute to prolonged stress response syndromes in the lives of veterans. Clearly, the growing body of research on the grieving process has taught us that the failure to overcome trauma by honest self-effacement and the recognition of denied emotions leads ultimately to distorted cognitions, feelings and impoverished human relationships. As a society we must overcome our collective tendency to avoid the difficult pain produced to our social fabric by the war. The Vietnam War was a different war from those in the past. Its legacy is profoundly different because the world we live in today is radically different than it was 40 years ago. It is this legacy that we must now examine in careful, scholarly and scientific ways. In terms of healing the psychic and physical wounds of Vietnam veterans the following list provides an overly simple categorization of urgently needed research.

IV. Areas for Future Research

1. Life-Span Developmental Research. In my earlier research I suggested that because of the configuration of personological variables and stressor experience in Vietnam, the identity of the veteran would be permanently altered and ever changing due to immersion in the death experience in combat. Clearly, longitudinal studies are needed to assess the many ways veterans have been affected by their war experience. This should include assessment of PTSD and its vicissitudes over age-related stages of ego-development. I submit, based on a careful review of the literature, that the assumption that survivors return to their old personality styles after a trauma is not only false but one manifestation of the denial process in society. PTSD is a transformative psychic process but we do not know how long it takes individuals to assimilate catastrophic stress into the self. Further, I believe that it is equally important to understand the character strengthening qualities which are exemplified in the prosocial-humanitarian mode of PTSD listed in Table 1. What set of variables permits some veteran to form this healthy integration whereas others remain profoundly numb and imparied by their war experiences?

2. Relation of PTSD to Physical Diseases and Illness. Although research on the veterans of WWII and Korea demonstrated a link between PTSD and proneness to certain physical disorders, e.g., ulcers and hypertension, we know very little at present in terms of the epidemiology of stress related illness among Vietnam veterans.

3. Relation of PTSD to Family Problems and Impaired Psychosocial Functioning. Since most veterans now are married and have begun raising families, the issue of how PTSD affects the family systems is important to

study in great depth. This is especially important since the literature on the Nazi holocaust has taught us that the effects of catastrophic stess can become transgenerational. Specifically, then, if a veteran suffers from PTSD, how does it impact on the family system? Do the spouse and children themselves exhibit stress disorders and related problems because of the father or mother's PTSD? These and many other questions constitute vital areas of research.

4. Prevalence of PTSD Among Female Vietnam Veterans. A neglected minority has been the famale Vietnam veteran. In particular, those who served in MASH units deserve special consideration to determine the nature and dynamics of PTSD in this population. At present, there is at least some clinical evidence to suggest that female veterans may have a higher incidence of sexual dysfunctions as a part of their PTSD. Additionally, there are special problems associated with impacted grief, loss and trauma in the care-providing role of a nurse, etc., which need to be studied in depth.

5. Relation of PTSD to Suicide. For many years now, outreach workers and clinicians treating Vietnam veterans have been greatly alarmed by the seemingly large incidence of suicide. Unfortunately, there does exist at present, a comprehensive study to document the prevalence of suicide among Vietnam veterans. I believe that such a study is critical and long overdue. If, in fact, the prevalence of suicide is higher than matched cohorts, identification of the relation of PTSD and service in Vietnam to such acts must be understood in order to design effective intervention strategies.

6. Relation of PTSD to Criminal Behavior. In a recent paper with my colleague, Dr. Sheldon Zigelbaum of Boston, Mass., we have begun to establish the link between PTSD and violent and non-violent criminal behavior. Our preliminary research and forensic experiences strongly suggest that most

Vietnam veterans who have committed crimes did not exhibit significant premorbid pathology nor a criminalogic core set of characteristics. A national study of incarcerated veterans should be undertaken to determine the causal variables associated with the disposition to engage in criminal behavior. Clearly, if a strong link can be established between PTSD and the disposition to commit criminal acts, then outreach efforts can be initiated to stem a destructive process for the veteran and society.

7. The Need to Evaluate the Effectiveness of the Readjustment Counseling Program. So far, all of the data gathered on "Operation Outreach" suggests that it has been an effective, cost-efficient readjustment counseling program. However, as is the case with all good programs, they tend to evolve new organization needs. I believe that the readjustment counseling program should be carefully evaluated against a number of criteria of program success. Further, new areas of service delivery should be studied as well. This includes: (1) increased funding and manpower, (2) improved and more frequent training of outreach workers, (3) applying research findings on PTSD to the issue of full recovery of the veteran to mental health, (4) offering multimodal therapies in the outreach center on both a short and long-term basis.

8. Relation Between Exposure to Agent Orange and PTSD. The growing concern of potential dioxin poisoning among Vietnam veterans necessitates that a study be directed to identifying the interactive psychophysiological mechanisms between exposure to the herbicidal agent and stress response symptoms. Beyond its intrinsic medical and psychological importance, such a study would have strong implication for the genetic and transgeneration consequences of exposure to dioxin compounds.

8. Relation Between Exposure to Agent Orange and PTSD. The growing concern of potential dioxin poisoning among Vietnam veterans necessitates that a study be directed to identifying the interactive psychophysiological mechanisms between exposure to the herbicidal agent and stress response symptoms. Beyond its intrinsic medical and psychological importance, such a study would have strong implications for the genetic and transgeneration consequences of exposure to dioxin compounds.

9. Need for New Measures of PTSD. Since PTSD is a unique mental disorder with specifiable antecedent stressor events, there is a need to develop new methods of assessing the syndrome. This is most germane to scientific studies suggested above, since with the exception of the Vietnam Era Stress Inventory (Wilson and Krauss, 1980), there is not at present a reliable and valid measure of PTSD for Vietnam veterans. Much research is necessary to perfect a battery of social-psychological measures to accurately and empirically assess PTSD.

10. Other Issues. There are many, many more important issues that need to be addressed by future research. Since my time is brief, let me simply list a few of them that come to mind at this time. (1) We need to assess the special needs of disabled veterans and study the prevalence of PTSD in this population. (2) Further, research is necessary on the effects of combat on economic success in comparison to matched cohorts. (3) The study of stress related premature aging needs to be addressed to identify veterans who may be at high risk for cancer, strokes and other serious diseases. (4) The interrelationship between social policies and societal attitudes and the problems of veterans deserves a great deal of consideration. (5) Finally, all of the issues considered in this paper should be placed within a larger value-moral-political context in terms of the meaning and consequences of war for mankind.

STATEMENT OF HARRIS STONE, EXECUTIVE DIRECTOR, JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Mr. Chairman and Members of the Subcommittee, I appreciate this opportunity to present the views of the Jewish War Veterans of the U.S.A. on the V.A.'s Psychological Readjustment Counseling Program for Vietnam-era veterans, and on H.R. 1443.

JWV has long supported the Vietnam "Vet Centers" that are authorized by this program. We have been impressed by the effectiveness of this program in providing professional counseling to Vietnam-era veterans. Our opinion is buttressed by our personal experiences.

JWV has been working on a new program to offer volunteer support to the Vet Centers in cooperation with the V.A. Although our "We Care About Vietnam Veterans" program (copy attached) has only been in operation for a short time, JWV members who volunteer in Vet Centers have reported seeing veterans make continued progress in overcoming their psychological scars. We believe that an important element in their progress is the counseling centers' atmosphere of trust and peer support.

The Vet Center program should not go out of existence on September 30, 1984—the current statutory termination date for this program. The need of Vietnam veterans for these centers' services will not end on that date. For one thing, one-third of these centers have only been open for a year and a half or less. Many veterans who now use these centers have been able to do so only for a short period of time.

In addition, the growth in the number of veterans using this program indicates the continually growing demand for these services nationwide and the popularity of the program among Vietnam veterans. The number of veterans who use this program annually has grown from 28,700 in fiscal year 1980, to 51,000 in fiscal year 1982. As of March 1983, 162,700 Vietnam veterans have used the program. An estimated 80,000 veterans will use this program during 1983.

We thus support H.R. 1443, which you recently introduced. Not only would this bill extend the life of the Readjustment Counseling Program, but it would also authorize studies which would update existing information on the readjustment status of the Vietnam-era veteran population. Both of these provisions are necessary. The most recent study of the readjustment status of Vietnam veterans, done by the Center for Policy Research, used 1978 data. We do not know how many additional Vietnam veterans could be in need of the Vet Centers' services, since no current data exists on the number of Vietnam veterans who are still in need of readjustment counseling. The studies that this bill would authorize would allow us to further understand the prevalence and types of the readjustment problems now facing Vietnam veterans and their families. The V.A. can use the results of these studies to further refine the readjustment counseling services to improve services to Vietnam veterans.

Hopefully, these studies will also indicate the number of veterans with readjustment difficulties who have not used the centers to date and allow us to understand why.

Back in 1978, the Center for Policy Research study estimated that 700,000 to 800,000 Vietnam veterans needed readjustment counseling services; the fact that only 20% of this estimate have used the vet centers needs exploration. In addition to the traditional reluctance among most people to seek psychological counseling, we believe the counseling centers, on a national basis, have not been in operation long enough to entice those reluctant veterans to approach them. This theory should be explored in the studies authorized by this bill.

The membership of my organization stands ready to work with you at any time to assure the continued success of the Readjustment Counseling program and the passage of this vital piece of legislation. Again, thank you for allowing the presentation of JWV views on this important matter.

WE CARE ABOUT VIETNAM VETS

For the last six months JWV has been working on a new program to offer volunteer support to the Vietnam Veterans Outreach Centers in cooperation with the Veterans Administration. Dr. Arthur Blank, VA Director of the Readjustment Counseling Service, a psychiatrist who saw duty in Vietnam, and Dr. Richard Shapiro, JWV National Vietnam Veterans Chairman, outlined the new "We Care About Vietnam Veterans" project at a convention workshop.

Dr. Blank explained why Vietnam veterans have different problems than former soliders from other American wars. People were sent to serve in Vietnam on 365 day rotations, which created constant turnovers in the fighting units. This system broke the bonds among comrades, leaving individual soldiers with the goal of survival rather than winning. In World War II, American soldiers knew why they were fighting and had strong support from the people back home. We all know of divided public opinion during the Vietnam war, and this had its effects then and now on the American soldier in Vietnam. Dr. Blank cited a 1980 Harris Poll of Vietnam veterans: 47 percent thought the war should never have been fought; 13 percent said they were still confused about the war or had no response; 40 percent thought they did the right thing.

In addition to the aftermath of being confused and unsure of the reasons for participation, American soldiers also are still experiencing the after effects of having participated in a guerrilla/terrorist war. According to Dr. Blank, there was always the threat of grenades being thrown; no one could be trusted.

The result of constant fear, mistrust and isolation was the enormous consumption of alcohol and dope. Dr. Blank said such "self-medication" didn't work as a "long term, lasting solution" to problems.

While the vast majority of returnees from Vietnam successfully made the transition from their service in Vietnam to productive civilian lives, it became very clear in the 1970's that the usual veterans programs were not reaching those veterans in need of readjustment help. In 1979, the bill establishing the Readjustment Counseling Program was signed into law; slowly but surely the program was established in 136 "out-reach centers," storefront operations, where the Vietnam vet could receive professional counseling and information in "non-traditional ways."

JWV has supported the creation and extension of this program, as well as other programs for Vietnam veterans. Now JWV is ready to bring human concern and assistance to the veterans and staff of the Vet Centers. JWV has given the Vietnam veterans political support; now JWV members can give them personal and moral support.

ESTABLISHING THE PROGRAM

To implement this program in every JWV echelon, sensitivity and care must be exercised. The "best intentions" could work against the professional goal of the Vet centers, and the Vet center leaders' suggestions must be heeded. Coordination with the vet center leaders and professionals is essential.

For an outline and complete details of the program, contact your Department Commander or JWV National Headquarters.

SUCCESSFUL PILOT PROJECT

At the Vet Center in Atlanta, JWV members have initiated this program. The following excerpts from an April 28 letter to Dr. Shapiro from David J. Lewis, ACSW, Team Leader at the Atlanta Vet Center, examines the results of JWV's efforts:

"The following are some of my thoughts about JWV's involvement with the Atlanta Vet Center: To date, JWV's involvement with the Atlanta Vet Center has been a very meaningful interaction. The feedback I have received from Vietnam vets about your visits and invitation to attend your meetings has been very positive. . . . Other than the Disabled American Veterans, the JWV is the only service organization that has had individual and intimate involvement with our center. Other service organizations have offered money and support, but your individual attention and personal involvement have been meaningful to our vets. As you know, most Vietnam vets feel personally rejected at all levels. This includes government, country, and service organizations. . . . Your organization by "just being there" has added a level of investment and involvement that they are unaccustomed to. They do care and, although many would not admit it, it is something that means a lot to them . . .

I certainly look forward to additional interaction with your organization and so do our fellow vets. There is excitement about the possibility of a spring picnic and ballgame. Hopefully, this will just be the beginning. The problems of Vietnam veterans are tremendous, but so are the rewards. Keep up the good work and please feel free to be in touch with me as necessary."

RESOLUTIONS: VETERANS AFFAIRS

Herbicide Exposure in Vietnam—Agent Orange—JWV again requests the expeditious completion of studies by independent scientific bodies of the medical effects of

Agent Orange on Vietnam veterans. JWV urges Congress to adopt legislation, which waives the present one-year time limitation on claims for service connected disability benefits, and which provides expanded medical treatment and other benefits to Vietnam veterans and their families who claim herbicide-related disabilities. JWV also urges all veterans who may have been exposed to herbicides in Vietnam to have a checkup at a VA facility to determine how they may have been affected.

Federal Cutbacks in Veteran's Programs—JWV adamantly opposes any attempt by this Administration, Congress, or the VA to eliminate veterans programs and services or target them for massive spending cuts. These programs meet needs and play a vital role in the lives of those who have sacrificed themselves on the battlefield and served their country bravely in peace and war. It is shortsighted and unfair of those who seek to control our nation's finances to try to balance the budget on the backs of veterans.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

on

VETERANS READJUSTMENT COUNSELLING ISSUES

MARCH 24, 1983

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
MARCH 24, 1983

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates this opportunity to appear before the Subcommittee today to present our views on a series of related issues that are extremely significant with respect to Vietnam veterans and their families; the status of the readjustment counseling program through the Vet Centers, the need for additional research on the readjustment and health of Vietnam veterans, and treatment provided by the Veterans Administration on an inpatient and outpatient basis for post-traumatic stress disorder. These issues are of great importance to The American Legion, and we thank the Subcommittee for its timely consideration of these matters.

Mr. Chairman, we will begin by addressing the provision of readjustment counseling through the Vet Center program, established under Public Law 96-22, and extended under Public Law 97-72. There are currently 136 Vet Centers and satellites across the country. There are also approximately 400 facilities providing counseling services under contract to VA.

The American Legion has found that the Vet Center program is doing well in accomplishing the purpose for which it was established - to provide readjustment counseling and referral services to those veterans who have not satisfactorily completed post-Vietnam recovery and readjustment processes. However, during the current climate of high unemployment the problems expressed by a large number of veterans seeking assistance at the Vet Centers are vocational in nature - employment and employment training - and many times the Vet Center teams are not prepared to deal with this problem, which is understandable, given the primary mission of the program. However, we have found that there has been some increased involvement in employment problems, particularly through the use of the Disabled Veterans Outreach Program. There are now about 120 DVOPs in place in 75 Vet Centers.

American Legion Field Service Representatives visit the Vet Centers during site visits to VA medical centers throughout the country, and their reports are complimentary of the program, and contain positive comments in the vast majority of instances.

Our statement presented to the Subcommittee on Oversight and Investigations on September 15, 1982 reflected that as of that time a total of 128,909 veterans had been seen at the Vet Centers during 541,481 visits. Figures available to the Legion on March 1, showed the total number of veterans seen had risen to 162,682 during 722,446 visits - an increase of nearly 34,000 veterans and 181,000 visits in a six month period. It is estimated that between 60,000 and 80,000 new Vietnam veteran clients will seek assistance through the Vet Centers during Fiscal Year 1983.

According to some experts who have substantial experience in diagnosing and counseling/treating veterans with post-traumatic stress disorder, we have only seen the "tip of the iceberg" in comparing the number of Vietnam veterans who have sought counseling for PTSD with the total number who have actually incurred at least some symptoms of the condition. This will be discussed in greater detail later in this statement.

Mr. Chairman, we are aware that you have introduced H.R. 1443, a bill that would, in part, extend by one year, until September 30, 1985, the period in which an eligible Vietnam veteran may request psychological readjustment counseling through the VA Vet Center program. Likewise, it would provide a one year extension of the date by which a transition of the readjustment counseling program from the Vet Centers into VA health care facilities is to be accomplished, and a six-month extension of the time in which the VA has to report to the Congress on the agency's plans for effecting such a transfer.

The American Legion believes that a one-year extension of the program is in order. Our belief is based upon the continuing influx of Vietnam veterans seeking assistance through the Vet Centers; the fact that there have been recent changes in the leadership of the readjustment counseling program which have led to the improvement of services, and that some of the Vet Centers have been operational for less than a year; as well as the previously mentioned findings by some mental health professionals that a much higher number of Vietnam veterans than originally estimated are suffering some symptoms of post-traumatic stress disorder.

It is also proposed in H.R. 1443 that the Administrator of Veterans Affairs conduct a comprehensive study of the readjustment of Vietnam veterans to civilian life. The study would include a nationwide survey of the prevalence and incidence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans and a survey of the health status of the Vietnam-era veteran population in relation to that of the general population.

It is proposed that each portion of the study be done with a sample of sufficient size to support statistically valid projections about the entire population of Vietnam-era veterans and would include separate statistical findings for veterans with service-connected disabilities, veterans who served in the Vietnam theater of operations, and women veterans.

The readjustment portion of the study would include a psychological evaluation, an economic evaluation in terms of income level and employment achievement and satisfaction, and a sociological evaluation including an evaluation of the extent and incidence of the long-term effect of post-traumatic stress disorders among Vietnam-era veterans on the families of and persons in other social relationships with the veterans. The survey is also to be designed to yield information to aid in determining whether there is a correlation between the occurrence of post-traumatic stress disorders in the Vietnam veterans and alcohol and drug abuse, and between the occurrence of PTSD and the incarceration of Vietnam veterans in Federal, State or local penal institutions.

The health status portion of the study would survey the current and past health status of the population, and the extent of and relationship between the occurrence of post-traumatic stress and related psychological disorders and the occurrence of psychobiological or medical disorders within the Vietnam-era veteran population. A determination would also be made of the extent of use by Vietnam-era veterans of Veterans Administration health care facilities.

Not later than December 31, 1984, the Administrator would be required to submit to Congress a detailed report on the study.

Mr. Chairman, the last comprehensive study of the readjustment of Vietnam veterans was accomplished, pursuant to the enactment of Public Law 95-202, through a contract with the Veterans Administration by the Center for Policy Research. The study is entitled "Legacies of Vietnam: Comparative Adjustment of Veterans and their Peers." Most of the data collection for this study was conducted between December 1976 and October 1979, and the report was transmitted to the Veterans Administration in March 1981. The goal of the study was to find the core of the problems incurred by Vietnam veterans so that the Veterans Administration's outreach program could be expanded to meet the needs that existed.

The American Legion found the Center for Policy Research study to be comprehensive. It identified many problems that needed solving. The study and ensuing report also addressed several recommendations contained in a 1978 report entitled "American Legion Study of the Psychosocial Adjustment Among Legion Veterans", by Charles R. Figley, Ph.D.

However, subsequent to "Legacies of Vietnam", much has been learned about post-traumatic stress disorder and the influence of its symptoms on Vietnam veterans, their families and friends.

Audie Murphy once said that you never really get over war - you never do. A majority of Vietnam veterans seemingly made a successful transition from the hostilities of combat, back into civilian society. It was discovered early on that others were undergoing serious readjustment difficulties brought on by post-traumatic stress disorder and other physical and psychological problems. It has recently been found that a significant number of those Vietnam veterans who had appeared to have made a rapid readjustment are now manifesting varying degrees of difficulty in maintaining employment, as some cannot remain on any one job for any length of time; problems in sustaining interpersonal relationships, which leads to intimacy problems because others do not feel they can trust or get close to their spouse, partner or friends; and other delayed reactions attributable at least in part to their military experience. According to some PTSD experts, between 30 and 60 percent of all combat veterans of Vietnam, plus additional non-combat veterans such as a number of hospital and graves registration personnel are suffering at least some symptoms of the disorder.

The American Legion feels that the study proposed by H.R. 1443 would provide an updated and accurate assessment of the current psychological and physical health status of the Vietnam Veteran population, and a basis on which the Veterans

Administration may plan immediate and future treatment modalities, and outreach activities, and we would support such an effort.

Mr. Chairman, with respect to the issue of diagnosis and treatment of PTSD in VA medical care facilities, the Legion has been evaluating this situation since early last year, when we received complaints from Vietnam veterans about the manner in which they were being treated at certain VA medical centers. In October 1982, our Field Service Representatives were instructed to closely review the provision of treatment for PTSD during site visits to each VA medical care facility, and to provide us with a detailed report of their findings.

What we have found thus far, Mr. Chairman, is a great deal of inconsistency. Some medical centers have no specific treatment program for PTSD. Others have developed inpatient and outpatient treatment and counseling programs; one facility has established contracts with mental health care providers and refers all veterans with a diagnosis of PTSD to them for treatment; another treats some PTSD cases and contracts for the care of others. Some medical centers stabilize adjunct conditions, then refer the veterans to a Vet Center for counseling.

One very disturbing conclusion that has been drawn from the site visit reports and complaints from American Legion Department Service Officers is that many VA physicians have differences of opinion regarding post-traumatic stress disorder, including the diagnostic criteria, and the credibility of a PTSD diagnosis. Unfortunately, it has been reported that some VA physicians discount any mention of Vietnam service or combat during an evaluation, and others do not elicit any military background at all during a PTSD examination.

We have seen cases, particularly during disability evaluation examinations for compensation purposes where, for instance, although the veteran exhibits symptoms such as recurrent dreams about being killed in Vietnam, startle response, limited social or interpersonal relationships, etc., etc., the examining physician arbitrarily states there is no evidence to support a diagnosis of PTSD. And while we realize that the adjudication of PTSD claims by VA regional office rating boards is not under consideration during this hearing, there is a relationship between the disability evaluation examinations and the rating of these cases, and it must be said we are finding some problems with respect to this relationship.

Our Field Representatives have been advised by some VA physicians that in their opinion the rating boards are not fairly and objectively evaluating PTSD claims where a diagnosis has been established.

To The American Legion these situations are serious, and we are currently in the process of developing a number of cases wherein problems concerning the diagnosis and/or rating evaluation exist, for the purpose of presenting them to the proper VA officials.

In post-traumatic stress disorder claims, the burden of proof concerning combat action or a similar life-threatening situation is placed upon the veteran. In most cases a veteran's military personnel records are silent, and there are few other avenues open to a claimant to obtain such information, aside from the veteran's recollection of the event or events.

The American Legion has learned during herbicide exposure research briefings by Mr. Richard Christian and other members of the Army Agent Orange Task Force, that it is possible for the Task Force to determine whether or not a veteran was present during a firefight or other catastrophe by reviewing morning reports, casualty reports, and records of combat actions. To the Legion it would seem prudent for the VA to explore this further, in order to assist Vietnam veterans in obtaining this information that is extremely important in the development of PTSD claims.

In conclusion Mr. Chairman, The American Legion will continue to monitor all activities relating to the handling of post-traumatic stress disorder by both VA medical care facilities and the regional offices. It is our intention to present to VA officials specific instances where perceived deficiencies or discrepancies exist in the diagnoses and rating decisions pertaining to claims of Vietnam veterans who feel they have incurred PTSD. Our Field Representatives will also continue their evaluation of the treatment of veterans diagnosed as suffering from this disorder. The American Legion insists that these Vietnam veterans who continue to bear the burdens of their war service, are to be treated in a compassionate and objective manner.

Mr. Chairman, that concludes our statement.

The
American
Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
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March 30, 1983

Honorable Bob Edgar, Chairman
Subcommittee on Hospitals and
Health Care
Committee on Veterans Affairs
House of Representatives
Washington, D.C. 20515

Dear Chairman Edgar:

This correspondence is in response to your request during the March 24, 1983 Subcommittee hearing for a summary of The American Legion's findings regarding inconsistency in the way post-traumatic stress disorder is diagnosed and treated within the VA medical care system, and in the manner in which PTSD claims are being evaluated by the regional offices. We have also addressed the question submitted by Congressman Bilirakis, as to what efforts are made by the Legion to inform our members of the availability of VA benefits, including medical care.

We were alerted to the fact that problems existed early in 1982 when we began receiving an increasing number of complaints from American Legion officials, Department Service Officers, and individual Vietnam veterans about the negative manner in which some veterans seeking medical assistance from and filing claims with the Veterans Administration for PTSD, were being treated. In October, our Field Service Representatives were instructed to conduct a review of the specific methods used to treat PTSD during site visits to each VA medical care facility. Also, our Department Service Officers and other accredited representatives of The American Legion have been requested to advise us of PTSD claims that have been denied because of inadequate examinations or overly stringent adjudication procedures.

The following information has been extracted from reports by our Field Representatives, and reflects the manner in which PTSD is handled at various facilities, the problems that have been identified by our staff, and in some instances by VA personnel.

VAMC Pittsburgh, October 25-29, 1982 - Veterans seeking care for post-traumatic stress disorder (PTSD) have been minimal at this facility. Treatment is available even if a claim is pending.

Veterans are encouraged to utilize the Veterans Outreach Center, plugged into individual and group therapy sessions, and receive medications, if necessary, as part of this treatment. Noted were the increasing number of veterans experiencing both PTSD and alcohol problems. The acting Chief was concerned that alcoholism tends to muddy the minds and decisions of the adjudication board.

A memorandum on VAMC Buffalo dated October 26, 1982, states that within the past year, formalized referral and a subspecialty clinic for the treatment of PTSD had been established in the Mental Hygiene Clinic. According to the Chief of the Clinic treatment had previously been available, however clients were not considered to have been properly diagnosed, and they were revolving through other services. Individual and group counseling is provided for veterans with PTSD, as it is felt that clients do not do well when mixed with general psychiatric patients. A specific inpatient unit of four beds is under consideration, but an important factor is getting the necessary resources. Initially there were difficulties with the adjudication of compensation and pension examinations. They were returned by the rating boards for more information, and required tremendous documentation. It was felt that 2507s regarding PTSD were more closely scrutinized than other claims. A meeting with the staff from the regional office clarified the situation, and claims are generally successful given the thorough clinical reports and improved documentation.

A report on PTSD at the VAMC New York, dated December 23, 1982 shows that regular treatment for PTSD commenced in September 1981, after staff attended a special VA training course. Within the last year only twelve veterans have been treated. If a veteran has other psychiatric problems besides PTSD, they are treated first. After the other conditions are stabilized, referrals are made to the Vet Center for outpatient treatment. If inpatient treatment is needed the veterans remain on the psychiatric unit. No special ward is available. If long-term treatment is required, the Montrose VAMC is used, as that facility has a 20 bed unit for the treatment of veterans with PTSD.

A memorandum dated December 28, 1982 reflects that the treatment of PTSD at the VAMC Salem, Virginia is an outreach program modeled after the Vet Centers, but not affiliated with them. Inpatient and outpatient treatment are provided to those veterans with symptoms consistent with a diagnosis of PTSD. There was at that time a caseload of 70 veterans, while another 50 were receiving treatment through contracts with three mental health centers. Salem maintains two outpatient groups for veterans with combat related PTSD, and a number of Korean veterans are included. Family and individual counseling are available. Inpatients are treated as part of the general psychiatric population. Compensation and pension examinations are done by fee basis physicians who may refer individuals to either psychologists or psychiatrists if they feel the need for further evaluation. A psychologist indicated that diagnostic criteria used by the VA is somewhat at odds with DSM III, in that the VA criteria involves a life threatening stressor. His experience has shown that nurses providing treatment or soldiers having burial (graves registration) detail had stressful situations where the resultant behavior is the same as that of life threatening situations. In meeting with the Department Service Officer of Virginia and his Staff, it was learned that there have been frustrations regarding the compensation and pension examinations. Veterans who they feel have all the recognized symptoms of PTSD are being diagnosed as having anxiety reactions. Other veterans who have been diagnosed as having PTSD by outside physicians (sometimes two of them) have not been given that diagnosis during the C&P examination. The Legion Field Representative, in speaking with various VA medical center personnel, had the impression that professional judgement is involved in the assessment, and there may be differences of opinion in determining the nature of a given condition.

A report on the treatment of post-traumatic stress disorder at the VAMC Altoona, PA dated February 7, 1983 notes that readjustment contracts were established with two mental health care providers in June 1982. The program is coordinated by a social worker assigned to outpatient treatment, and there had been 53 referrals as of that time. It was reported that there had been some problems since the program started, in that for the first six months no guidelines were available from VA Central Office, so the hospital had to run the program as best they could. After the guidelines were received some changes had to be made. It was learned that one veteran who was attempting to get into the program felt he was being hasseled and left. He ended up in jail and attempted to hang himself.

A memorandum on the treatment of PTSD at VAMC Coatesville, PA dated February 9, 1983 reflects that a 12 bed unit was established in January 1982. Previously, veterans with PTSD were treated on a regular psychiatric unit. Since the bed service was opened, approximately 40 veterans had been seen, some repeaters. The main treatment is intensive group therapy. Some individual therapy, family groups, and medications are also used when deemed necessary. The length of stay is 90 days, but this is flexible. One veteran stated he had been there about a year, and he had been a patient on a psychiatric unit for a year prior to that. Post-discharge follow-up was limited and sporadic. Referrals are made to the Vet Centers in Baltimore, Philadelphia and Wilmington, but attempts to see veterans at the medical center after discharge were not very successful. The Legion Field Representative spoke with two veterans and both felt the program is worthwhile and helpful. The biggest problem seemed to be trying to establish a claim. One of the veterans was successful in getting a service-connected evaluation rated at 30 percent disabling, but has not been able to secure a retroactive effective date, back to the time the PTSD problems first were recognizable. The reason, according to the veteran, is that the psychiatrist at the East Orange VAMC did not understand the problem and would not diagnose it. The other veteran stated that his claim has been continuously denied. He said the VA keeps finding "technicalities" on which to turn it down.

With respect to the treatment of PTSD at the Lebanon, PA VAMC, a memorandum dated February 17, 1983 states that no specific treatment program for PTSD has been developed at the facility. If a veteran requires inpatient treatment, he is admitted to one of the units and follows the course of treatment. There has been a reluctance on the part of veterans to transfer to the special program at VAMC Coatesville. A psychologist holds group sessions for Vietnam veterans at the Harrisburg outpatient clinic, but our Field Representative was unable to contact him.

A memorandum on the Butler, PA VAMC dated February 17, 1983 shows that services for PTSD were initiated at this facility approximately two years ago. Although statistics are not kept, the caseload was estimated to be 19 veterans in the weekly group, 6 to 8 wives in the partners group, and 4 to 6 veterans seen individually. All personnel providing services have other primary duties. There are three contracts with community mental hygiene clinics in the medical center catchment area. Veterans are diagnosed as having PTSD based on the criteria in DSM III, which was reported to be always fully documented. A problem has been encountered with compensation and pension examinations by those veterans seeking service connection for PTSD. About 150-200 veterans had been referred from this medical center to the Pittsburg Regional Office for compensation and pension examinations, because the Butler facility does not have a Psychiatry Service. At that time, none of the veterans' claims had been service-connected by the regional office. In a subsequent conversation with the Chief of Staff it was learned that contact had been made with the Adjudication Division at the regional office to initiate a meeting to discuss what could be done to improve the situation. One recurrent complaint that surfaced during inquiries about PTSD and the problems with C&P examinations was the alleged poor rapport and extremely brief examinations attributed to one of the psychiatrists at the regional office. Complaints were expressed by veterans and VA professional staff, and verified by the Legion Service Officer.

A memorandum regarding a visit to the San Francisco VAMC dated March 9, 1983 pertains specifically to problems with the manner in which PTSD cases are adjudicated by the San Francisco Regional Office. Certain medical center officials related to our Field Representative that PTSD claims are not being fairly considered. It is felt that the problem is due to stringent adjudication, and a more objective approach should be implemented in the consideration of these claims. One official stressed that objectivity was absent from the rating evaluations. It was generally felt that a rating board psychiatrist, more so than the system itself, is the source of the problems with the PTSD claims.

A memorandum dated October 8, 1982 regarding the treatment of PTSD at the VAMC Sheridan, Wyoming states "The Chief of Psychiatry said that there is no separate treatment program for PTSD. He said that to do so would be a mistake because it is a questionable diagnosis and could be made claimable."

As was stated during the hearing, The American Legion will continue to evaluate the treatment of PTSD in the VA medical care system, and the manner in which claims are evaluated by the VA regional offices. It is our plan to initiate meetings in the near future with Veterans Administration officials to discuss The American Legion's concerns regarding this important issue, and to point out our specific findings. While we are aware that problems do not exist in every medical center or regional office, it is disturbing to know that any Vietnam veteran is not receiving fair and equitable treatment by the Veterans Administration.

. . . .

Congressman Michael Bilirakis requested that we provide the Subcommittee with information regarding the efforts used by The American Legion to encourage the use of the VA medical care system and other Veterans Administration benefits and programs by our members and other veterans.

The Legion's approach to the dissemination of such information is multifaceted. Each year the National Commander spends a majority of his term in office traveling the United States and other parts of the world, speaking to American Legion audiences as well as other community groups and civic organizations. More often than not his message contains some mention of veterans benefits and programs. Likewise, representatives of our National Veterans Affairs and Rehabilitation, and Legislative Commissions, as well as other American Legion officials present numerous speeches and presentations during Department (State) conventions, midwinter conferences, service officer schools, leadership colleges and other forums.

The American Legion Magazine is received monthly by every member of the organization, plus numerous other individual subscribers, VA medical centers and Vet Centers, libraries, etc. Each edition contains an update on veterans issues, and several times during the year in-depth articles on veteran-related topics appear in the publication.

ADVANCE, a National Headquarters publication for Post Commanders and Adjutants is published monthly, and mailed to every Post. The majority of the time articles on veterans' rights, benefits or programs are included in this widely distributed publication.

The American Legion's National Public Relations Division issues a weekly release entitled American Legion News Service (ALNS) to each Department Headquarters for use in the State Legion newspapers, local newspapers, and other media. Included are news releases on changes in eligibility for veterans benefits including medical care, statements by the National Commander and various Legion officials regarding veteran matters, excerpts of testimony presented before the Congressional Veterans Affairs Committees, etc. The Public Relations Division also maintains a toll-free news hotline that provides a daily message of interest including updates on benefits and programs for veterans, their dependents and survivors to Legionnaires and other inquiring individuals.

The National Legislative Commission publishes the Legislative News Bulletin, containing the latest Congressional action on the VA medical care program, benefits, funding, and other related issues on a monthly basis. All Posts and individual Legionnaires and members of the American Legion Auxiliary are encouraged to subscribe to this publication which currently is received by approximately 7,600 individuals per month.

The National Veterans Affairs and Rehabilitation Commission mails out VA&R Memorandums and Bulletins approximately 100 times per year for the purpose of providing the latest information available on Veterans Administration programs, including changes in regulations, availability of benefits and medical care, studies surveys relating to VA benefits, and a myriad of other issues.

The National VA&R Commission also publishes annually a manual for Post Service Officers that is provided mainly for the use of all Post Service Officers, but is also regarded by many others in the veteran community as a valuable compilation of information on how to apply for VA medical care, compensation, pension, dependency and indemnity compensation, educational benefits, and other benefits and services provided by the Veterans Administration and the Armed Forces.

There are also pamphlets and other publications issued by the National Organization and some Departments that contain information of this nature, not to mention the efforts of a large number of the 16,000 local American Legion Posts to inform the veterans in the community of their eligibility for benefits and programs administered by the Veterans Administration, and to offer assistance in applying for them.

The American Legion appreciates this opportunity to provide you with this information.

Sincerely,

John Sommer

JOHN F. SOMMER, JR.
Deputy Director
National Veterans Affairs and
Rehabilitation Commission

STATEMENT OF
STEPHEN L. EDMISTON
ASSOCIATE DEPUTY
NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
MARCH 24, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 750,000 members of the Disabled American Veterans I wish to thank you for inviting us here today to express our views on H.R. 1443--a bill to extend for one year the VA's Psychological Readjustment Counseling Program and to require the VA to conduct a study on the readjustment of Vietnam veterans.

H.R. 1443

Introduced on February 15, 1983, by you, Mr. Chairman, H.R. 1443 proposes, through appropriate amendment to Section 612A of Title 38, U. S. Code, to extend for one year the VA's authority to operate the Psychological Readjustment Counseling Program for Vietnam Era veterans and extend from April 1, 1984 to September 30, 1984 the date on which the VA must report to the Congress on its findings and recommendations relating to the Psychological Readjustment Counseling Program.

Section 2 of the bill requires the Veterans Administration to conduct a comprehensive study of the readjustment of Vietnam Era veterans to civilian life.

As part of the proposed study, the bill requires the Veterans Administration to:

1. Determine the prevalence and incidence of post-traumatic stress disorder and related adjustment problems among Vietnam Era veterans;
2. Compare the health status of the Vietnam veteran population with that of the general population;
3. Provide separate statistical findings for veterans with service-connected disabilities, veterans who served in the Vietnam Theatre of Operations and women veterans;
4. Include a psychological, economic and sociological evaluation of Vietnam Era veterans in the readjustment portion of the study;
5. Correlate the relationship between post-traumatic stress disorder and drug/alcohol abuse, incarcerated Vietnam Era veterans and the occurrence of psychobiological or medical disorders among Vietnam Era veterans; and
6. Determine to what extent VA health care facilities are utilized by Vietnam Era veterans.

The report to the Congress on the study mandated by Section 2 of the bill would be due no later than December 31, 1984.

* * *

As you know, Mr. Chairman, the DAV has continually expressed its commitment and concern for assisting those veterans who suffered psychological problems as a result of their military service in Vietnam. Based on the findings of the study funded by the DAV entitled "The Forgotten Warrior," we initiated the DAV's Outreach Counseling Program for these veterans. Subsequently, the Congress passed legislation, now embodied in Public Law 96-22 authorizing the VA to establish a Psychological Readjustment Counseling Program for Vietnam Era veterans. We were pleased to have been a part of the early efforts to reach out to veterans of the Vietnam War and to lend our support to the bill authorizing the VA Program.

Although the VA's Psychological Readjustment Counseling Program had a slow and rocky beginning, in our view, the VA's system of storefront Vet Centers have proven to be highly successful in assisting Vietnam veterans and their families.

Mr. Chairman, the DAV does support the one year extension of the VA's Psychological Readjustment Counseling Program proposed in H.R. 1443. There remains a substantial number of veterans who continue to utilize the VA storefronts and contract counseling services.

While we believe the Program is necessary and will be utilized well beyond the expiration of the proposed 1985 extension, we also feel that the Veterans Administration should embark on a program to include such services within the VA or other government facilities and to begin bringing the Program into the mainstream of traditional VA health care programs. By doing so, we believe that the Veterans Administration would be better prepared to deal with many of the questions and concerns you wish addressed by the study proposed in H.R. 1443.

In this connection and recognizing that one of the reasons for establishing storefronts and contract counseling was based on the fact that many Vietnam Era veterans objected to the administrative red tape at federal facilities, we strongly recommend that the VA attempt to identify its hospitals and other government facilities wherein the Program could function and, at the same time, overcome the objections of veterans.

Simply put, Mr. Chairman, the VA should identify medical facilities which could establish separate units for psychological readjustment counseling--assigning specific areas where veterans can go, receive counseling treatment and leave without meeting with the usual VA outpatient administrative procedures.

Contract Services

With your permission, Mr. Chairman, I wish to express our concern regarding VA's contract counseling services provided as part of the Psychological Readjustment Counseling Program.

As we understand it, the fee for services on contract counseling provided to veterans by private physicians was originally authorized by Congress as an extension of the VA's Outreach Program. The contract provision of counseling services was established to provide such services to veterans in need of care in remote areas where there did not exist a convenient storefront location.

The DAV strongly supported contract counseling as an overall part of the Psychological Readjustment Counseling Program.

However, it has come to our attention that, at least in one city, funding for contract counseling services is being expended in a fashion that, in our view, was not intended by the Congress.

I refer to the award of such a contract in Denver, Colorado, where the private mental health care counseling provider is located within two miles of the existing VA Vet Center providing the same services to Vietnam Era veterans.

In addition, we have learned that this contract will utilize nearly one half of all of the funding provided in that state for fee basis counseling.

Our concern, Mr. Chairman, centers around whether or not veterans in the remote and outlying areas of Colorado will receive needed counseling services. Further, we suspect that similar problems may exist in other states.

Accordingly, we respectfully request that your Committee mandate the VA to make public a list of all of the fee basis counseling contractors to insure that such funds are expended as intended by Congress--that is, to provide psychological readjustment counseling services where none exist for veterans in need of such care.

This completes my statement, Mr. Chairman. Thank you again for allowing us to express our views on these most important subjects.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

PHILIP R. MAYO, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO
THE READJUSTMENT COUNSELING PROGRAM FOR
VIETNAM VETERANS

WASHINGTON, D.C. MARCH 24, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to the Veterans Administration's Psychological Readjustment Counseling Program and HR 1443, a bill introduced by you to extend by one year the period during which Vietnam-era veterans may request psychological readjustment counseling from the VA and to direct the Administrator of Veterans Affairs to carry out a comprehensive study of the prevalence of post traumatic stress disorder and related readjustment problems among Vietnam-era veterans.

As you know, Mr. Chairman, Public Law 96-22 created the "Readjustment Counseling Program for Veterans of the Vietnam Era." The program established storefront operations, "Vet Centers," throughout the Nation to reach and engage Vietnam-era veterans for

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the purpose of providing readjustment counseling for those veterans outside the medical framework of the Veterans Administration, without the necessity of applying a diagnostic "label" on them. This would enhance their transition into the "mainstream" of society. This concept represented a radical departure from the traditional delivery of health services within VA medical facilities; that is, traditionally, a diagnosis must be rendered prior to the delivery of services.

It is our view that the 136 centers now in operation are meeting the needs of the veterans who seek aid and assistance through them. One of the major areas in which veterans have sought help is in employment related problems. Since the last hearing, up to 25 percent of the Disabled Veterans Outreach Program (DVOP) personnel have been authorized to become a part of these centers. In another area, the General Accounting Office recently found that the centers were effectively addressing the readjustment and other needs of women veterans.

The importance of the information staff are accumulating regarding Vietnam veterans suggests (as envisioned in HR 1443) that much can be learned that will be beneficial to the VA in assisting Vietnam veterans, and also veterans of earlier and possible future conflicts, in effectively melding their attitudes with the "mainstream" of society. Successful research to explore the possible application of what is learned in the vet centers requires stability within this program -- the operation of all

136 centers and a purposeful, stable management of the program for a reasonable measure of time. Inasmuch as the VA now has a new Administrator and many of the centers have been open for less than a year, coupled with the fact that 70 to 80 thousand new veteran contacts are projected during FY 1983, we believe the program, as is presently structered, has to be extended for at least one year. The Administrator and his staff need this time to conduct a comprehensive evaluation of the program; the employees, who for the most part are working on temporary appointments, need the assurance that they will be employed and that a reasonable effort will be made to intelligently assimilate them into the VA system in the future.

Vietnam and other veterans deserve a cogent and sympathetic review of this program. The resolution of their present and possible future problems demands the exploration of the impact of stress on the health of veterans. The increasing incidence of alcohol and drug abuse among Vietnam veterans bears testimony to the fact that research is needed.

Of great concern regarding this program, Mr. Chairman, is the need for additional resources - both human and physical - to provide inpatient treatment for Post Tramatic Stress Disorder (PTSD). Waiting lists for psychological treatment indicate that Vietnam veterans are not receiving the treatment they so desperatly need, thereby forcing vet centers to deal with inpatient needs on an outpatient basis. Either greater VA hospital resources for inpatient PTSD treatment should be provided or greater contracting authority be allowed. A combination of both is also an option to explore. The success of the VA Vet Center project is contingent upon the combined support of the Congress and the VA Administrator along with the dedication of existing vet center staff.

Mr. Chairman, the need for the timely enactment of HR 1443 is obvious; we urge the Subcommittee advance it at the first opportunity.

TESTIMONY OF JOHN F. TERZANO, NATIONAL LEGISLATIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

Mr. Chairman and members of the Committee. My name is John Terzano, and I am the National Legislative Director of the Vietnam Veterans of America (VVA). I am honored to be here today to testify before the Subcommittee on Hospitals and Health Care of the House Veterans Affairs Committee. We are here today to address the Veterans Administrations's (VA) Operation Outreach Vietnam Era Vet Center Readjustment Counseling Program.

VVA has a long history of supporting the concept of the Vet Center program, and since its inception in 1979, we have continued to support the program. We believe that some major steps have been taken in the last year to improve the program, from the level of the VA Central Office out to the most remote satellites of the Vet Centers. We applauded the choice of Dr. Arthur Blank as the new director of the program, as well as his recent selections for other top level administrative and management staff of the program. In addition, he has augmented the staffs of the regional coordinators, so that they are no longer as totally overwhelmed as they once were.

VVA strongly endorses H.R. 1443, introduced by Congressman Edgar, which would provide for extension of the Vet Center program and would provide for a comprehensive study of the prevalence of post-traumatic stress disorder and related readjustment problems among Vietnam-era veterans. We, however, would go a step further with the legislation. We would propose a three year extension of the Vet Center program, rather than a one year extension. The justification for the three year extension is twofold. First, a three year extension would take the program totally out of the political process and thus the centers would have the ability to do the job they need to do, that is, to provide services to those veterans of the Vietnam-era who need such services. Second, because there is a clear and overwhelming need to expand the program, it would be, in our estimation, useless to implement such an expansion if, by the time the centers are established and on line, it is time for them to begin phasing out and closing. We would also propose that the study recommended in this legislation include not only disabled, women, and Vietnam theater veterans, but also include minority veterans. We have been saddled for years by the assumption that a veteran is a veteran is a veteran, and we must recognize and address the fact that a Vietnam veteran is not a Vietnam veteran is not a Vietnam veteran. It would be important to learn from such a study what might be the differences in these populations.

Let me expand on our proposals and the reasons for the proposals.

Since 1979, the Vet Center program has grown to a total of 136 centers and satellites. During the past four years, the number of veterans seen has increased considerably. Figures gathered by the program indicate that the following activity has occurred:

1. The number of new clients seen in the program each year has increased over one hundred and sixty percent from 1980 to 1983.
2. Approximately 29,000 new clients were seen in 1980, and approximately 80,000 new clients will be seen in 1983.
3. The total number of veterans who will have been seen in the program by the end of fiscal year 1983 is estimated to be approximately 240,000.
4. The total number of contacts made by the centers by the end of fiscal year 1983, that is visits in units of fifteen minutes, is estimated to be in excess of 2 million.

It is the opinion of the majority of researchers that the number of Vietnam veterans who will require readjustment counseling may be upward of 700,000. Even recognizing the large numbers of veteran clients who have already been seen, clearly there are close to a half million veterans who may still require readjustment counseling services. Obviously, we have not even peaked yet on the number of veterans who could use the services of the Vet Center program.

The structure of the teams presently consists, on an average, of four people. Of those four, generally only three are in counseling positions, while one is in an administrative or office management position. Of the three counselors, one is the team leader, whose administrative activities and paperwork consumes approximately twenty five to fifty percent of his or her time. This leaves approximately two and a half people doing counseling in each center. There are a total of 567 employees in the program. Approximately 400 people are doing counseling at any given time. That means that for the 80,000 new clients who will be seen in 1983, each counselor will see on average 200 new clients. This is in addition to the clients the counselors already have. Of the two million contact visits which will occur in 1983, each counselor will have approximately 5,000. This is an extraordinary amount of work being done, and again, is in addition to the client load each counselor already has. It should be noted that fifty percent of the clients seen in the program are seen for longer than two months.

The figures indicate a clear need to expand the program, as well as to extend it. The ideal number of additional centers would be ten or twelve, and with those new centers and team expansions which are needed, an addition of approximately 200 full time employees would be necessary to handle the incredible client load.

There is also a continuing need for additional research, and H.R. 1443 addresses that need. However, the question must be raised, where will the money come from to do that research. The program has $31.4 million allocated for this year. Of that, approximately $21.2 million will be used for operation of the centers. $11.2 million has been alloted for contract fee services, of which it is estimated approximately $7 to $8 million will be spent. That leaves about $3 million which could be used for the research or for the expansion. Clearly, there is not enough for both to be done. The question then becomes, where will the extra money come from? It is our opinion that the Congress should appropriate the extra funding for these activities.

The Vet Center program has been shown to be extrmely cost-effective. The centers provide excellent services at a lower cost than can be provided by other existing VA programs. Perhaps this committee needs to look into the actual cost of services provided to veterans by the Vet Centers as compared to those other VA programs. We are quite sure that the figures would substantiate this contention.

There are many other areas which must be addressed in order for the program to achieve its true potential. There is a need for professional back-up for each team. This person would be able to provide assistance to the team with difficult cases, and would be available to the team members themselves for counseling. We must recognize that the employees in this program are in highly stressful jobs. They deal with life and death matters frequently. They work long hours, listening to the pain of others. They have a need for stress management assistance, and such a back-up professional could provide that. It is difficult for a member of the team to function in that capacity since the team members are all involved intricately in the day to day stress of working in the center.

Our feeling is that the ideal team should consist of a counseling professional such as a psychologist, psychiatrist, MSW, or RN, as well as street level outreach people and a support staff. Presently, about half of the teams have such counseling professionals on staff. We believe that for those teams which do not have such professionals on staff the need for back up professionals should take first priority.

There is one area of stress on the employees which we believe should be dealt with immediately. That is the area of job security. Most of the employees in the program are Schedule A personnel. This means that in effect, they are temporary employees, and are subject to termination at any time if the program is terminated. During the past four years of the program, we have seen at least one period during which the employees did not know from one day to the next whether they would have a job the next year. During that time, a number of highly qualified people left the program because they had serious concerns about this. If the program is not extended, we can expect large numbers of people to leave beginning next October when the program will again be on the downswing. Good, high quality clinicians have become demoralized and discouraged by the situation. We cannot expect to continue to attract the kind of people needed in the program if this situation continues. The Vet Center employees need to be appointed to career or career conditional positions. There are nearly a quarter of a million employees in the VA system. The approximately 325 Schedule A employees of the Vet Center program would be merely a drop in the ocean of VA employees in terms of assimilating them into the system if the program were cancelled in the future. There are approximately 172 VA hospital and 200 clinics which could surely use these talented people if the program ended.

There is also a serious disparity in salary levels within the program. Presently, the VAMC parent facility sets the grade and salary level for the Vet Center teams. This results in personnel in different centers doing the same job having very different monetary compensation. A clerical person in one center could be a GS 4-5 or even a 7, while a person doing the same job in another center is a GS 3-4. The intent of the Congress was that this program should have autonomy, and we believe that this is another area which should be controlled by the Central Office of the Readjustment Counseling Service. There could then be some standardization of salaries and grades.

The parent facilities have the ability to set certain other policies pertaining to Vet Center personnel, such as overtime policies. In some centers, a policy has been set by the parent facility that there will be no overtime. Outreach requires flexibility in time schedules. That is one of the things which differentiates the Vet Center program from other VA programs, and the parent facilities may not recognize that need. If a counselor has to deal with a crisis intervention situation, he or she cannot say to the veteran that it is time to leave. Often, outreach activities occur on the weekends, and if the counselors do not receive compensation for such work, again, how can we expect to retain good people? Such policies should be the province of the Central Office of the Readjustment Counseling Service, not the parent facilities. We have good administration there now. Let us use them to their fullest capacity.

In the area of special populations, there are a number of issues to be raised. Female veterans, minority veterans and disabled veterans have not yet received the kind of attention which is needed. In September of 1982, Dr. Blank called together the first working group on special populations. That group addressed the area of women Vietnam era veterans. Its recommendations are only just beginning to be implemented. There are still working groups to be convened in the areas of minority and disabled veterans, and it will be some time before those meetings occur and the recommendations presented and implemented. There is a need to reconstruct outreach materials so that those populations can be reached and their needs met. There is a need for training of the counselors to be able to deal with those populations once they do come into the program. There is almost no research available on these veterans. The program needs to have the time to gather the information needed to address these people, and it needs to have the time to outreach and help them once that information has been gathered.

Incarcerated veterans are still a serious problem. There is recognition that Post Traumatic Stress Disorder (PTSD) may be a significant element in the incarceration of some Vietnam veterans. Yet, the Vet Center counselors may only go into the prisons to deal with veterans who are soon to be released. Are we to let those veterans who may have another several years in prison continue to have nightmares and other problems related to PTSD for those years and only address them when they come out? By that time, the Vet Center program could be no longer in existence, and those veterans will again have nothing to assist them. Many of them may have been incarcerated prior to the establishment of the program, and they are kept in limbo while assistance is available. The program should be helping them during their incarceration and in the readjustment to life after they leave prison. We need to allow and encourage the Vet Center program to go into the prisons and deal with those veterans.

The Vet Center are supposed to be advocates for the veteran in many areas. The best of the centers are those which are multi-service centers, providing assistance in the areas of readjustment counseling, discharge upgrading, educational assistance, employment assistance and the like. It must be recognized that a veteran with multiple problems who receives assistance in only one area is like a car with three flat tires. If you put air in the counseling tire and none in the educational, employment, and discharge upgrading tires, the car will not go anywhere. A veteran who receives counseling to deal with his or her PTSD and who receives no help in gaining employment, will be right back again in a few months with the same problem. The Vet Center program is becoming more clinically, professionally oriented, and that is good. It is important, however, the we not lose sight of the advocacy role the centers need to take in other areas.

The Vet Center program has done an amazing job in its short history. There is much more which it has the talent and capability to do. The program must, however, have the resources with which to do its job. The employees in the program are highly motivated, dedicated individuals who need the support of this Congress and the VA. We strongly urge you to show that support by considering carefully the proposals we have made, and by implementing them.

Thank you for your attention.

Prepared Statement of Hon. Bill Richardson, a Representative in Congress From the State of New Mexico

Mr. Chairman, I would like to take this opportunity to thank you for conducting this important hearing on the Veterans Administration's Readjustment counseling program for Vietnam-era veterans and to receive testimony on your bill, H.R. 1443, and H.R. 2213, introduced by my good friend and colleague, Mr. Mica.

I have conducted my own review of this program in my district. As a result of my review, I believe this program must be extended for many reasons, including the ones I will share with you.

First, the number of veterans seen at the local centers in New Mexico has increased monthly since the vet's center opened in Albuquerque in 1980. There were over 1,400 veterans treated in the first calendar year of operation. Last year, the total number of veterans treated increased almost 250 percent. In short, the program is working, and the veterans in my State are learning of its importance more and more every day.

Second, the district I represent is largely rural. Approximately 80 percent of the Vietnam-era veterans are of Hispanic or Native American origin. Statistically, New Mexico had the third highest casualty rate, per capita, in the Vietnam war, with 50 percent of the casualties being of Hispanic origin.

Mr. Chairman, I have learned Vietnam veterans in my district have only recently begun to overcome their fears and begin to participate in this important program. According to people I have talked to, this reluctance was based largely on social and cultural differences. A psychologist told me that treatment for these veterans must be handled in a different manner than for most Vietnam veterans seen in other parts of the country. On this point, Mr. Chairman, the personnel in our vet's center in Albuquerque and in our satellite office in Gallup are now prepared to use new treatment methods designed to effectively treat veterans from Hispanic and Native American backgrounds. I would be very reluctant to see the program be phased out beginning next year if these veterans and the treatment facilities are, as I indicated, only now really beginning to find each other.

This leads me to my third point. In New Mexico, there are many inherent difficulties in providing and maintaining consistent services to the Vietam-era veteran population from the Albuquerque vet's center, which only has four employees. One problem is the center's geographic location. Another is inadequate center staffing. For a long time there has been a feeling in the veteran population in my district that the current vet's center belongs to urban Albuquerque and is not a part of their community. The Gallup satellite I referred to earlier has only two employees and is isolated from much of the rest of the district. I believe, at a minimum, another satellite in the northern and eastern part of my district would be of invaluable assistance to the 5,300 Vietnam veterans in that area in overcoming difficulties which they may have in adjusting to civilian life.

So you see, Mr. Chairman, my interest is certainly not in seeing this program phased out. Instead, it is in seeing that the program be improved in my district through expansion of personnel and facilities. I think the staff psychologist in Albuquerque summed it up best when he said recently: "Maintaining consistency and continuity in counseling over large geographical distances is difficult, if not impossible. There are four counselors including one psychologist." Mr. Chairman, I know that these four individuals work very hard, during regular hours, evenings, weekends and holidays. But they need more help, and I think an extension of this program is an important first step.

PREPARED STATEMENT OF HON. JAMES M. SHANNON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

I want to ask this Committee's support for a very small, very inexpensive project—but one that has been tremendously important for veterans in my part of Massachusetts.

On July 19, 1982, the Veterans Administration established a temporary Veterans Outreach Center in Lowell, Massachusetts. The Center was designed to serve those veterans who were not able to travel the approximately thirty miles to the main Massachussetts Veterans Center in Brighton.

The Lowell Center was originally scheduled for temporary operation, and was due to close in September of 1982. But from the first, the Center proved to be a clear success. Hundreds of veterans, many of whom would find it difficult or impossible to reach Brighton, used the Center. Its operation was extended until January 31, 1983. But at that point funding ran out and the Center was closed.

I don't need to tell the members of this Subcommittee how important support services are to veterans—particularly Vietnam veterans. The strong emotions you can see any day or night that you visit the Vietnam Veterans Memorial here in Washington is but one indication of how strongly Americans feel about our veterans who made such great sacrifices in that war. We remember the dead with monuments. But we can do far better by those who lived and who are now turning to us for support.

Our government could keep a strong Veterans Outreach Center in Lowell open for $30,000 a year. That's two $15,000 salaries—for a director and a counselor. An office is available through the General Services Administration.

In the six months that the Center was open, it was able to serve over 500 veterans and their families. It assisted with jobs, counseling, alcoholism problems, drug abuse, and a variety of other veterans issues. The Lowell area is a distinct geographic region and I know for a fact that many veterans who used the Lowell Center simply won't make it to the Brighton Center.

I ask the members of this Committee to do all you can to make available the $30,000 that would again open the doors of the Lowell Veterans Center. We owe it to these people who served us so well.

For the record, I am attaching other letters and documents which underline the effective services that this Center provided. I hope that Committee members will look at these materials. I think you'll be impressed and agree that $30,000 is a very small price to pay for such a sensible, practical program.

43 Jewett St.
Lowell, Ma. 01850
617-452-9310

March 24, 1983

To Whom It May Concern,

In regards to Operation Outreach Vietnam Era Vet Centers,
As a Vietnam Combat Veteran, I have utilized the facilities of the Brighton, Ma. Outreach Center in 1980-81. I must say that this center was the turning point of my life. At the time, my life was in complete shambles, and I could not understand why. I heard about the center in Brighton, Ma. and somehow got myself down there. It was then, and only then, that I found out I was having readjustment problems. If it wasn't for that center helping me to deal with my problems, I might not be writing this right now.

I know personnally that the Outreach Centers are doing far more than was expected of them. For in July of 1982, I with the help of the Brighton Center, opened a temporary Satellite Center in Lowell, Ma.. In the six (6) months the center was opened, I have worked with and helped over five hundred (500) veterans and their families. If there was ever a need for a program that really helps the veterans in this country, then Operation Outreach is it.

Enclosed you will find a status report and letters of support, for Operation Outreach Vietnam Era Vet Centers, in particular, the former Lowell center. If there is anything you can do to help Operation Outreach, it would be greatly appreciated.

Remember those
who carry the scars
(in mind and body)
of this country's
battles.

Ron Gleason.

Ron Gleason

Vet Center

STATUS REPORT
JULY 19, 1982 - JANUARY 19, 1983

Outreach Contacts - 65
Crisis Intervention - 44
Drug & Alcohol Counseling - 33
Job Assistance - 31
Benefits - 46
Outside Referrals - 10
Phone Contacts - 17
Readjustment Counseling - 140
Community Events - 13
Mens Rap Group - 51
Womens Rap Group - 50

COMMUNITY EVENTS

July 20, 1982 - Presentation on Outreach Center to D.A.V. in Lawrence, Ma.
July 30, 1982 - Presentation on Outreach Center to Mayor and City officials of Lowell, Ma.
Aug. 16, 1982 - Agent Orange Presentation to Merrimack Valley Vietnam Vets
Aug. 25, 1982 - Presentation on Post Traumatic Stress Disorder to Greater Lawrence Psychological Center
Sept. 13, 1982 - Presentation on Post Traumatic Stress Disorder to general public and Merrimack Valley Vietnam Vets Inc.
Sept. 29, 1982 - Presentation on Outreach Center to general public
Oct. 23, 1982 - Wreath laying ceremony with Merrimack Valley Vietnam Vets
Nov. 12, 1982 - Presentation on Outreach Center to city manager, Lowell, Ma.
Nov. 14, 1982 - Name reading vigil with Merrimack Valley Vietnam Vets
Nov. 19, 1982 - Presentation on substance abuse by Vietnam Vets to U. Lowell students
Nov. 24, 1982 - Presentation on Outreach Center to C.E.T.A.
Dec. 8, 1982 - Presentation on Post Traumatic Stress Disorder to D.A.V. in Lawrence, Ma.
Dec. 15, 1982 - Presentation on Post Traumatic Stress Disorder to womens group and general public at Billerica library

Massachusetts
Veterans' Service Agents Association, Inc.

c/o OFFICE OF VETERANS' SERVICES
TOWN HALL
WILMINGTON, MASSACHUSETTS 01887
Telephone (617) 658-3311

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LEGAL OFFICER
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September 21, 1982

Mr. Art Blank, PHD
Director, Readjustment
Counseling Service (11RC)
V.A.C.O.
810 Vermont Ave., N.W.
Washington, D.C. 20420

RE: Operation OUTREACH
Vietnam Era Vet Ctr.
Lowell, MA

Dear Mr. Blank:

The Mass. Veterans Services Agents' Association strongly supports and feels it's imperative that the funding of the above captioned OUTREACH Center in Lowell, MA continue.

We Veterans Agents across and through out the Commonwealth of Massachusetts are well aware of the needs of the Vietnam Veteran and the problems they have of readjustment.

We are very much aware of the help the Lowell OUTREACH Center has rendered and strongly and sincerely urge that it be allowed to continue operating and also to be funded on a long term basis.

The OUTREACH Center's record of help to Vietnam Veterans is one of outstanding positive accomplishment.

Sincerely Yours for Veterans,

Paul A. Farrell
Paul A. Farrell
President
Mass. Vets Service Agts. Association

*(In Memoriam)

The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133

ROBERT A. VIGNEAU
23RD MIDDLESEX DISTRICT
5 ELM AVENUE
BURLINGTON

CHAIRMAN
COMMITTEE ON LOCAL AFFAIRS

TELEPHONE
OFFICE 722-2400
HOME 272-0611

Erwin R. Parsons, P.H.D.
Regional Coordinator
Region I (116-E)
F.D.R. V.A.M.C.
Montrose, NY 10258

Dear Dr. Parsons:

As a member of the Massachusetts Legislature and a World War II veteran, I am aware of the need of veteran assistance organizations. It has now been brought to my attention that a Veteran Outreach Center in my representing area is about to close its doors on September 30, 1982, because of lack of funding.

The Operation Outreach Vietnam ERA Vet Center in Lowell, serving a large industrial metropolitan area of northeastern Massachusetts, should be permitted to remain open. This particular center has a success record of serving their fellow vets that our area can boast of, and to allow the center to close would be devastating.

It is my intent to inform you that my constituents have been served well by this center. I urge you to make every effort to reconsider your decision and allow this gravely needed center to remain open.

Sincerely,

ROBERT A. VIGNEAU
State Representative

cad

Department of Medicine
and Surgery

Washington D.C. 20420

Veterans
Administration

In Reply Refer To: 11RC

NOV 10 1982

Mr. Albert A. Richard
46 Agawam Street
Lowell, Massachusetts 01852

Dear Mr. Richard:

I am writing in reponse to your letter to the President which was received at the Veterans Administration on October 14, 1982. I thank you for your expressions of concern for the readjustment counseling services to Vietnam combat veterans which are being provided by the temporary Vet Center satellite in Lowell, Massachusetts.

I am aware of the importance of the services at present and therefore it has been determined that this temporary Vet Center satellite will be kept in operation as long as is feasible.

Thank you for your interest and concern.

Sincerely,

DONALD L. CUSTIS, M.D.
Chief Medical Director

Vet
Center
50 Kearney Sq.
Lowell, Ma. 01852
Tel. 453-1746
Ext. 49

January 21, 1983

Dear Mr. Walters,

I am writing you in regards to Operation Outreach Vietnam Era Vet Center, located in Lowell, Ma.. This center services the Merrimack Valley Area, which has a population of approximately 60,000 Vietnam Era veterans. This center was opened July 19, 1982 as an extension of the Brighton Ma. center. We were suppose to be open for just three (3) months so that we could reach the veterans in this area. A lot of these veterans cannot make it to Brighton, which is forty (40) miles away, and is the closest center to this area. We were due to close on Sept. 30, 1982, but this center was so successful, the veterans in this area started complaining about the closing. The Veterans Administration granted us an extension for as long as this center was needed. Now they say we are closing as of Jan. 31, 1983, and that there is nothing that can be done about it. I read in the D.A.V. magazine (Jan. 83 issue) that you stated, ("Concerning the Post-Traumatic Stress problems experienced by many Vietnam Era veterans, some Vietnam Era veterans are still engaged in the readjustment struggle. I have a special concern for them and know that we cannot rest until we have assisted all those who need it") I sincerely hope you meant what you said that day. For after checking and comparing the stats of this center with other centers, I am sure you will realize that there is a definite need for this center. Keep in mind, Mr. Walters, that this center is and has been run by one man since mid Sept. 1982. When we opened up in July of 1982, there were two (2) men on this staff, myself and Frank Barber, a counselor. Mr. Barber left in mid Sept. for a more secure position with a private outfit. It was bad enough we lost one of the best counselors in the country, now the V.A. wants to shut us down. I don't understand it, here is a center that is doing more than was expected of it, and the V.A. is just ignoring the facts. I think you will find from the letters I have enclosed and the stat report, what this center has done and can do, if it is allowed to remain open to provide a vitally needed service to the veterans in this area. I sincerely hope, Mr. Walters, that you can and will do something to help the vets in this area.

Remember those who
carry the scars of
this countrys battles.

Ron G Gleason
Ron Gleason
Outreach Worker vc2

TOWN OF TYNGSBOROUGH
MASSACHUSETTS
OFFICE OF
VETERANS' SERVICES

September 15, 1982

Mr. Erwin R. Parsons P.H.D.
Regional Coordinator
Region I (116-E)
F.D.R. V.A.M.C.
Montrose, N.Y. 10258

Dear Mr. Parsons:

I would like to take this opportunity to thank you for the "Operation Outreach" program in Lowell, Mass. So many years have gone by, since the needs of our Vietnam Era Vets have been properly addressed.

As Veterans' Agent in the Town of Tyngsborough, I have seen first hand the professional help the Veterans of Tyngsborough have received from Mr. Barber and Mr. Gleason. The unselfishness and dedication of these two men are certainly a plus for our Veterans, as well as a positive reflection on your organization.

Realizing full well that many stats are being kept on the success of this program, I will not go into fine detail. However, I would like to point out that without your program, there are many Vietnam Veterans in my town that would not be back on the road to full recovery from their diverse problems. These Men are also once again able to hold their heads high because they are making a solid contribution to themselves, their family, and the society that sent them off to fight in the most costly and misunderstood war in our history.

It is obvious to me, that you realized our Vietnam Veterans needed help and because of this need "operation Outreach", was born. These Men are being helped daily and as word spreads about the wonderful work being done at the Lowell, Mass. Vet Center more are sure to come to get badly needed counseling.

Men like you Mr. Parsons, will always rise to the occasion when our fighting Men need to be helped as our Vietnam Veterans do. It is very gratifying to me personally to be in touch with fine men such as Mr. Gleason and Mr. Barber. And far more rewarding when I see the very positive results from their counseling and dedication.

TOWN OF TYNGSBOROUGH
MASSACHUSETTS
OFFICE OF
VETERANS' SERVICES

Page 2 of 2

September 15, 1982

It is the hope of this office, that this very successful program "Operation Outreach", continues to be fully funded. So many of our Veterans need it, and it is the very least our citizens can do to make "Our Boys" as fit as they were before being shipped off to that Hell we all call VIETNAM.

Thanking you again, I remain

Very truly yours,
Dept. of Veterans' Svc.

Kevin V. O'Connor
Kevin V. O'Connor
Veterans' Agent

CAROL C. AMICK
SENATOR
5TH MIDDLESEX DISTRICT
18 CRESCENT AVENUE
BEDFORD, MA 01730
HOME TEL. 275-2644

COMMONWEALTH OF MASSACHUSETTS
MASSACHUSETTS SENATE
STATE HOUSE, BOSTON 02133

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STATE HOUSE, BOSTON
ROOM 416A
TEL. 722-1571

October 27, 1982

Erwin R. Parsons, Ph.D
Regional Coordinator
Region I, (116-E)
F.D.R. - V.A.M.C.
Montrose, NY 10258

Dear Dr. Parsons:

I am writing to bring to your attention the invaluable services provided to Vietnam Veterans by the Operation Outreach Vietnam Era Vet Center in Lowell, Massachusetts, which is operating on a temporary ninty-day extension in funding, scheduled to expire December 30, 1982.

In addition to sponsoring information presentations, the Lowell Vietnam Era Vet Center provides a variety of guidance and referral programs for Vietnam Veterans and their spouses, including drug, alcohol, psychiatric, and individual counselling. The importance of a Vietnam Veteran's Center offering these services in the Merrimack Valley region cannot be overemphasized, especially when considering the fact that the nearest facility with a similar program is located in Manchester, New Hampshire.

Operation Outreach is an established program that successfully meets the needs of area Vietnam Veterans, and as such I urge you to support the Center's request for permanent status with the Veterans Administration.

Sincerely,

Carol Amick

CAROL C. AMICK
State Senator

CCA:lmd

RAY KOGOVSEK
3RD DISTRICT, COLORADO

430 CANNON HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
(202) 225-4761

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Congreſs of the United States
House of Representatives
Washington, D.C. 20515

March 23, 1983

The Honorable Bob Edgar
Chairman
Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I would greatly appreciate your assistance in placing this letter in the record of the hearings held by the House Veterans Affairs Subcommittee on Hospitals and Health Care on March 24, 1983, regarding Vietnam veterans readjustment programs.

Sincerely,

Ray Kogovsek

RAY KOGOVSEK
Member of Congress

RK:lbw

Enc.

LONG RANGE READJUSTMENT PROGRAM

L.R.R.P.

2777 Grand Court
Grand Junction, Colorado 81503
(303) 241-0491

March 21, 1983

Congressman Ray Kogovsek
430 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Kogovsek:

Recently, I became aware of a hearing of the House Veteran's Affairs Subcommittee on H.R. 1443 scheduled for March 24, 1983. I am writing this letter to provide both some input to your office and to respectfully request that this letter be submitted to the subcommittee for their record.

I am both a professional administrator and a professional counselor. I have worked with Vietnam Veterans as a counselor both during my last 1½ years in the Army (72-74) and a number of years in the drug abuse field (74-79). I am, additionally, a Vietnam Combat Veteran. I served with the 173 Airborne during 69-70 in the Tiger Mountains of Vietnam.

I am concerned with several issues about the Vietnam Readjustment Counseling Program, including:

1. The lack of available funds to establish an adequate readjustment counseling system.

2. The general lack of readjustment counseling service available to the Vietnam Veteran.

It is my opinion that the current situation surrounding Post Traumatic Stress Disorder (PTSD) is much like the drug abuse epidemic of the 1970's. The full extent of the impact of the social problems created by the Vietnam Veteran are only beginning to be felt by society. Durrently, the readjustment counseling program is placing limited resources in communities to deal with the problems of the Vietnam Veteran. I feel this is a stop gap measure as this approach does not allow for various services to be available to the veteran, based on the intensity of the readjustment problems experienced. The current, limited approach requires that the veteran mold himself to the readjustment counseling offered - the readjustment counseling services offered cannot be tailored to the needs of of the veteran.

Therefore, I feel that it is imperative that a "systems approach" to the provision of readjustment counseling services be implemented, if the problems created by the Vietnam war are to be efficiently and effectively dealt with. This entails that a mirad of services need be available to the Vietnam Veteran. Such services should be directed to a target population, I recommend a target population of 45% of eligible veterans, with 20% of this population being treated by the existing Veterans Administration system and 25% receiving services from the readjustment counseling program. Services should include:

1. Local treatment entry points.
2. A variety of local service providers to provide:
   a. Extensive psychological evaluation
   b. Psychiatric services
   c. Psychological services
   d. Counseling services

An advantage of this approach is that no one service provider is being over burdened with a difficult to work with client, which will decrease burn-out rates of professionals in the field. Additionally, the Vietnam Veteran seeking the readjustment counseling services can be "matched" with a service provider that can best work with him, thus treatment should be more effective and cost efficient.

The current approach for providing readjustment counseling is similar to the approach to providing drug abuse services in the early 1970's. Stop gat measures were taken by establishing one type of treatment program, namely Methadone Clinics. It was not until about 1975 that a system of drug abuse treatment facilities was accepted as being needed. In the late 1970's a system approach to drug abuse was being implemented, which was more effective and efficient, however, funds also began to be reduced. This resulted in a floundering system that would have been effective in treating drug abuse and reducing chemical dependency in this country.

I urge the lawmakers of this country to not make this same error again. It seems that it will be more effective and efficient to support a readjustment counseling system at this point in time rather to continue to provide only stop gap limited funding for services that are not only needed but are owed to the Vietnam Era Veteran.

To illustrate my point let me point out some interesting figures from the Grand Junction, Colorado area. According to a recent solicitation for contract proposals from the Veterans Administraiton Medical Center in Denver, Colorado, there are 2500 Vietnam Veterans in the Grand Junction area eligible for readjustment counseling services. Currently, about 20% (500) of these veterans are receiving services on an annual basis at the local Veterans Administration Medical Center. If it is true that 45% of the Vietnam Veterans need some type of readjustment counseling services, then in this area there is another 25% (650) of the veterans needing services.

Assuming that only the veteran and no one else in his immediate family needs any counseling services and that each veteran can resolve his/her problem in average of 15 hours of intensive readjustment counseling then the minimum number of service hours per year needed in the Grand Junction area is 1750 hours/year or 188 hours/week. At this point in time the Veterans Administration is preparing to contract to provide a stop gap 26 hours/week of readjustment counseling in the Grand Junction. I am sure the same situation exists in every population center in the United States.

The need for Vietnam Veteran readjustment counseling services is evident, the methodology that is chosen by this country to provide those services is still up for debate. I urge you and the House Veterans Affairs Subcommittee to support adequate funding for the readjustment counseling program in such a manner that an adequate, effective and efficient counseling system can be established. This I feel will be more cost effective in the long run although the cost today will be considerably higher than a stop gap system.

Thank you for considering my comments. If I can be of further assistance, do not hesitate to contact me.

Respectfully submitted,

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Combat Veteran of Vietnam
Director, L.R.R.P.

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